

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03364

## 03360 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 1 Route #2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 1 Route #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) LINDA		First	Middle	Last	4. DATE OF DEATH Mar. 7	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH March 7, 1957	9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Gary Ausherman		14. MOTHER'S MAIDEN NAME Juanita Klipp						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Gary Ausherman		Route #2 Address Hagerstown, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Pulmonary atelectasis and pulmonary hypoplasia				INTERVAL BETWEEN ONSET AND DEATH 6 days		
751X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		DUE TO (b) Congenital diaphragmatic hernia with large and small bowel contained in left pulmonary cavity				Indefinite		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
19								
21. I certify that I attended the deceased from March 7, 1957 to March 7, 1957 that I last saw the deceased alive on March 7, 1957, and that death occurred at 9:10A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED
ACTUAL SIGNATURE B. B. Kneisley						148 West Washington St.		3/8/57
PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.				Hagerstown, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/8/57		22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		ADDRESS W. H. G. H. B. Kneisley		24a. REC'D BY REGISTRAR Mar. 8, 1957		24b. REGISTRAR'S SIGNATURE B. Kneisley		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

CERTIFICATE OF SEATH

BUREAU V. S.

MAR 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr Hoffman

03365

03361

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>2 Yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>111 Broadway</b>		d. STREET ADDRESS <b>111 Broadway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>JOHN LARKIN</b>		First	Middle	Last	4. DATE OF DEATH <b>March 6 1957</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Sept 13 1877</b>	9. AGE (In years, lost birthday) <b>79</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Technician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Tenn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Soddy Hamilton Co USA</b>		
13. FATHER'S NAME <b>William Henry Barnes</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Gross</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>123-07-0087</b>		17. INFORMANT <b>Melchiora G. Barnes 111 Broadway</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>				Hagerstown Md.		INTERVAL BETWEEN ONSET AND DEATH		
400.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Generalized Arteriosclerosis								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cirrhosis of liver</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>				
21. I certify that I attended the deceased from _____, 1954, to March 6, 1957, that I last saw the deceased alive on March 5, 1957, and that death occurred at 9 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <b>Lloyd A. Hoffmann</b>				ADDRESS (Street, city or town, state) <b>Hagerstown, Md.</b>		DATE SIGNED		
PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffmann</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/8/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Hagerstown Wash. Co Md</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>Mar. 8, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Blair H. Bowes</b>		

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BUREAU OF INVESTIGATION  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

BUREAU V. 2

MAR 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Dr Weeks  
03362 CERTIFICATE OF DEATH

03366

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland		c. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 10 Min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 833 Pope Ave	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				d. STREET ADDRESS 833 Pope Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM		First DURWARD	Middle BOONE	4. DATE OF DEATH March 21 1957	Month 19	Day 19	Year 19
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept 27 1879	9. AGE (In years lost birthday) 77 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard Pangborn Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Libertytown Fred Co Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John C. Boone		14. MOTHER'S MAIDEN NAME Arie Bohn					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tax. no. or unknown) No		16. SOCIAL SECURITY NO. 317-09-9809		17. INFORMANT Fanny R. Boone		Address 833 Pope Ave Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Belmoy E. Bohn				INTERVAL BETWEEN ONSET AND DEATH hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from on March 21, 1957, 19, that I last saw the deceased alive on March 2, 1957, and that death occurred at 3 p. m., from the causes and on the date stated above. ACTUAL SIGNATURE Howard N. Weeks, M.D.		ADDRESS (Street, city or town, state) 136 North Potomac St. DATE SIGNED 3/22/57					
PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.		Hagerstown, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/23/57		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash. Co Md (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		24a. REC'D BY REGISTRAR Mar. 25, 1957, by <i>Howard N. Weeks</i> 24b. REGISTRAR'S SIGNATURE					

CHIEF'S COPY OF DOCUMENT OR INFORMATION IS

CHIEF'S COPY OF DETAIL

BUREAU V. 4

MAR 27 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)  
SM 9/55

03363 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03367  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Pennsylvania b. COUNTY Allegheny	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsburgh 25 x 3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 265 Lebanon Ave.	
3. NAME OF DECEASED (Type or print) Samuel		First George	Middle Bowman
Last		4. DATE OF DEATH March 25 1957	Month Day Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH February 14, 1893
8. AGE (In years (last birthday) 64 yrs.		9. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Organ Builder		10b. KIND OF BUSINESS OR INDUSTRY Own Business	
11. BIRTHPLACE (State or foreign country) Washington County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Henry Bowman		14. MOTHER'S MAIDEN NAME Ida Warbel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W. W. I	
17. INFORMANT Mrs. Anna H. Bowman Pittsburgh Pennsylvania		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 arteriosclerotic coronary heart disease DUE TO coronary artery thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Acute coronary occlusion DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 1944			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none
20f. (City or town) —		(County) — (State) —	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE S. Robert Wells		DATE SIGNED Mar. 26 1957	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 3/27/1957	
22c. NAME OF CEMETERY OR CREMATORIUM South Side Cemetery		22d. LOCATION (City, town, or county) Pittsburgh, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home Hagerstown, Md. R. Franklin Rouser		24a. REC'D BY REGISTRAR Mar. 29. 1957	
ADDRESS		24b. REGISTRAR'S SIGNATURE Joseph Baccaro	

RECEIVED  
BUREAU V. S.

APR 1 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03368

Reg. Dist. No. 302

03364

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		b. COUNTY <b>Washington</b>	
c. LENGTH OF STAY IN lb <b>5 weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Co. Hospital</b>		d. STREET ADDRESS <b>224 E. Antietam St.,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Virginia</b>	First <b>H</b>	Middle <b>Brown</b>	Last 4. DATE OF DEATH <b>3 14 19 57</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 28, 1879</b>
9. AGE (In years last birthday) <b>78</b>	10. IF UNDER 1 YEAR yrs. Months <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b>	12. IF UNDER 24 HRS. Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>saleswoman</b>	
10c. BIRTHPLACE (State or foreign country) <b>Wash. Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Huron Huyett</b>		14. MOTHER'S MAIDEN NAME <b>Lydia Shupp</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-28-6147</b>	
17. INFORMANT <b>Mrs. W. F. Hopkins</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		<i>Coronary insufficiency</i> <i>Cancer Lung (R) after unknown</i> <b>cause</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/1/45</b> , 19, to <b>3/14/57</b> , 19, that I last saw the deceased alive on <b>3/13/57</b> , 19, and that death occurred at <b>1:00</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hagerstown, Md.</b>			
ACTUAL SIGNATURE <i>Scar Young</i>		DATE SIGNED <b>3/14/57</b>	
PHYSICIAN'S NAME (Type) <b>SEARL Young</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>3-16-57</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Rose Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>Mar. 16, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Chas H. Goovers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

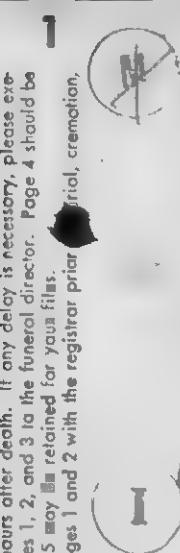
BUREAU Y. S.  
RECEIVED

MAR 19 1957

WISCONSIN STATE PENITENTIARY - BARNSBURY, WI  
CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form M3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. <i>302</i>		
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE West Virginia b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Martinsburg							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In Automobile rear 260 S. Mulberry Ave					d. STREET ADDRESS Rural					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Middle Last			4. DATE OF DEATH		Month	Day	Year			
Butts, William Edward					March 13				19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 8, 1886		9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Conductor		10b. KIND OF BUSINESS OR INDUSTRY B & O R. R.		11. BIRTHPLACE (State or foreign country) Morgan County		12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME George Butts					14. MOTHER'S MAIDEN NAME Mary Rebecca Kefarot							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N.		16. SOCIAL SECURITY NO. no		17. INFORMANT		Mrs. Alma Ellis		Address Martinsburg, W. Va.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> INTERVAL BETWEEN ONSET AND DEATH												
DUE TO <u>Arteriosclerotic myocardial heart disease</u>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>grade iv with failure</u>												
DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>										
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. None 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) —		(County) —		(State) —		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .												
ACTUAL SIGNATURE <i>S. Robert Wells</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										DATE SIGNED 3-13-57
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-16-57		22c. NAME OF CEMETERY OR CEMINATORY Rosedale		22d. LOCATION (City, town, or county) Martinsburg		(State) W. Va.				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard K. Brown</i>		ADDRESS Martinsburg W. Va.		24a. REC'D BY REGISTRAR <i>Mer 12 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Robert Bowers</i>						

BUREAU A. M.

MAR 15 1957

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**C3366 CERTIFICATE OF DEATH**

Reg. Dist. No. 302  
**03370**

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 16 <b>21 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Martin Manor Convalescent Home</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
3. NAME OF DECEASED (Type or print) <b>WALTER</b>		First <b>HARVEY</b>	Middle <b>CAISMER</b>
4. DATE OF DEATH <b>March 22 1957</b>		Month <b>March</b>	Day <b>22</b>
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>February 3, 1896</b>
9. AGE (In years lost birthday) <b>61 yrs.</b>		10. IF UNDER 1 YEAR Months <b>1</b>	11. IF UNDER 24 HRS Days <b>19</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Carpet Company</b>	11. BIRTHPLACE (State or foreign country) <b>Chicago, Illinois</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William Calsmer</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Hansen</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>no</b>	
16. SOCIAL SECURITY NO <b>321-03-5289</b>		17. INFORMANT Address <b>Franklin V. Calsmer Hagerstown, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.  (b) DUE TO  (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>By arteriole Cardiac Vasculitis Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAY UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Place of residence</b>		20f. (City or town) <b>Hagerstown</b>	
(County) <b>Maryland</b>		(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>1957</b> to <b>1957</b> , that I last saw the deceased alive on <b>1957</b> , and their death occurred at <b>10:15 A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>R. H. Buckley</b> PHYSICIAN'S NAME (Type) <b>V. A. Beachley</b>		ADDRESS (Street, city or town, state) <b>Hagerstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/26/1957</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Elm Lawn Cemetery</b>		22d. LOCATION (City, town, or county) <b>Elmhurst</b>	
(State) <b>Illinois</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Jones Funeral Home</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>Mar. 22, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Franklin A. Ayer</b>	
VS A15 (4) 15M 9/55			

RECEIVED  
1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be attached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 03367

03371

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived) a. STATE MARYLAND	
		If institution: Residence before admission b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 795 HAMILTON BLVD.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
3. NAME OF DECEASED (Type or print) SARAH		First JANE	Middle GEARFOSS
4. DATE OF DEATH 3		Month 7	Day 19
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH APRIL 21, 1870		9. AGE (In years last birthday) 86 yrs	10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homeduties		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) WHITE HALL, MD.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ISSAC NEEDY	
14. MOTHER'S MAIDEN NAME CATHERINE GRIFFIE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO NONE		17. INFORMANT MRS. EDNA C Brinton HAGERSTOWN, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyperensive arteriosclerotic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 3, 1957, to March 7, 1957, that I last saw the deceased alive on March 7, 1957, and that death occurred at 2:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Physician's NAME (Type) Archie Robert Cohen, M.D.		ADDRESS (Street, city or town, state) Clear Spring, Md. DATE SIGNED 3/18/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-9-57	
22c. NAME OF CEMETERY OR CREMATORIAL BROADFORDING		22d. LOCATION (City, town, or county) BROADFORDING (State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE FRED W. KRAISS HAGERSTOWN, MD.		24a. REC'D BY REGISTRAR Mar 11, 1957	
		24b. REGISTRAR'S SIGNATURE Chas H. Bowers	

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REGISTRATION

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film

03372

03368

Dr Binford

Reg. Dist. No. 302

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 6 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION sh. County Hospital		d. STREET ADDRESS 130 West Washington st	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ELIZABETH	Middle VIRGINIA	Last COFFMAN
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 57 ? yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Seamstress		Montgomery- Ward	Hancock Wash Co Md.
13. FATHER'S NAME John Coffman		14. MOTHER'S MAIDEN NAME Frances Colbert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 219-05-9908	17. INFORMANT
No		Miss Lilla B. Coffman	Address 130 W. Washington St Hagerstown Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 340.3		Starvation - Puhl. embolism 4 + weeks.	
DUE TO		Meningitis	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		3 months	
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Decubitus ulcers, Thrombosis of vein, Carr.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
p.m.			20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 30 Nov. 1956, to 31 Mar 1957, that I last saw the deceased alive on 31 March 1957, and that death occurred at 3 p.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard T. Binford		ADDRESS (Street, city or town, state) 1135 Patowmack ave Hagerstown, Md. 19 April 1957	
DATE SIGNED			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/3/57	22c. NAME OF CEMETERY OR CREMATORIUM River View Cemetery
		22d. LOCATION (City, town, or county) Hancock W. sh. co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		24a. REC'D BY REGISTRAR Apr. 2, 1957	
		24b. REGISTRAR'S SIGNATURE Richard Dowers	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr E. V. Ditto Jr

03373

03369

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Hagerstown		c. LENGTH OF STAY IN 1b 16 Hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital		d. STREET ADDRESS 13 East Greene St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First LESTER	Middle NORMAN	Last CONNER	4. DATE OF DEATH March 25 1957	Month 19	Day 25	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb 5 1882	9. AGE (In years lost birthday) 75 yrs.	10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months 0	Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor Heating & Plumbing		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia Co		12. CITIZEN OF WHAT COUNTRY? Cedar Creek Shenandoah USA	
13. FATHER'S NAME George W. Conner		14. MOTHER'S MAIDEN NAME Susan M. Whittington		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-16-3838		17. INFORMANT Mrs Caroline L. Conner 13 E. Green St Funkstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Cause of death lying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH 7 mo 3 wks	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 5</u> , 1957, to <u>March 25</u> , 1957, that I last saw the deceased alive on <u>February 24, 1957</u> , and that death occurred at <u>Hagerstown Md.</u> from the causes and on the date stated above.				ADDRESS (Street, City or town, state) M.D. <u>Hagerstown Md.</u>		DATE SIGNED <u>3/25/57</u>	
ACTUAL SIGNATURE <u>E. V. Ditto</u>							
PHYSICIAN'S NAME (Type) <u>E. V. Ditto</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-27-57		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash. Co Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS		24a. REC'D BY REGISTRAR Mar. 29, 1957		24b. REGISTRAR'S SIGNATURE <u>Glenn Bowers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
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REAU V. S.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18** 03374  
**03370 CERTIFICATE OF DEATH** Dr Sullivan  
 Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>34 Hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		d. STREET ADDRESS <b>217 No Cleveland Ave</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>TERRY</b>		First	Middle	Last	4. DATE OF DEATH <b>March 23 1957</b>	Month	Day	Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 23 1957</b>	9. AGE (in years less birthday) <b>2 yrs.</b>	10. IF UNDER 1 YEAR <b>Months</b>	11. IF UNDER 24 HRS. <b>Days</b>	12. IF UNDER 24 HRS. <b>Hours</b>	13. IF UNDER 24 HRS. <b>Min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Ellis Cox Jr</b>				14. MOTHER'S MAIDEN NAME <b>Loretta Teague</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Ellis Cox Jr 217 Cleveland Ave</b>		Address <b>Hagerstown Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atelectasis</b> DUE TO <b>7544</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) <b>Congenital Heart Disease</b> <b>Prematurity</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>5-22</b> , 19 <b>57</b> , to <b>3-23</b> , 19 <b>57</b> , and that I last saw the deceased alive on <b>3-23</b> , 19 <b>57</b> , and that death occurred at <b>6:30</b> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>St. Mary's County, Md.</b> PHYSICIAN'S NAME (Type) <b>E. Mary</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/23/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>				24a. REC'D BY REGISTRAR <b>Mar. 25, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Sherrill Rosevere</b>		

RECEIVED  
BUREAU V. A.

MAR 27 1957

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

03375

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		b. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS 151 W. Washington St.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		151 W. Washington		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First John	Middle Joseph	Last Dachtler	4. DATE OF DEATH March 30	Month	Day	Year 19 57	
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 3, 1914	9. AGE (In years old birthday) 42 yr.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY electrical work		11. BIRTHPLACE (State or foreign country) Albany, N. Y.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Frederick Dachtler				14. MOTHER'S MAIDEN NAME Barbara Ferbert					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW <b>IK</b> 062-12-4047		17. INFORMANT Mabel Dachtler, Hagerstown, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary occlusion</u> INTERVAL BETWEEN ONSET AND DEATH									
4-8-0-1 DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)									
DUE TO									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none							
20c. TIME OF INJURY Month, Day, Year Hour a. m. none p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town)		(County)	(State)
						—		—	—
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>S. Robert Wells</i>		DATE SIGNED April 1 '57							
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4-4-57		22c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cem.		22d. LOCATION (City, town, or county) Fort Myer, Va.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		ADDRESS		24a. REC'D BY REGISTRAR Apr. 5, 1957		24b. REGISTRAR'S SIGNATURE <i>Chas. Powers</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-tombstone permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

100-1257

SEARCHED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03376

03372

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 hour	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland	
3. NAME OF DECEASED (Type or print) NAPOLEON		First MIDDLE DASHNAW	4. DATE OF DEATH March 21 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tooling Foreman		10b. KIND OF BUSINESS OR INDUSTRY Aircraft Company	11. BIRTHPLACE (State or foreign country) Ogdensburg, New York
13. FATHER'S NAME Louis Dashnaw		14. MOTHER'S MAIDEN NAME Delema Spooner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-09-7400	17. INFORMANT Mrs. Anna J. Dashnaw Hagerstown, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO Cerebral Hemorrhage by extension and contusion. (b) Cerebral and spinal contusion (c) Nephrosclerosis.	
		INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
		INTERVAL BETWEEN ONSET AND DEATH several years.	
		INTERVAL BETWEEN ONSET AND DEATH several years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M., from the causes and on the date stated above. ACTUAL SIGNATURE Physician's NAME (Type)		ADDRESS (Street, city or town, state) M.D. 159 W. Woolington St Hagerstown, Maryland DATE SIGNED 3/22/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/25/1957	22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery	22d. LOCATION (City, town, or county) Hagerstown, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE Super-Houser Funeral Home R. Franklin Renger	ADDRESS Hagerstown, Maryland	24a. REC'D BY REGISTRAR D. 1957	24b. REGISTRAR'S SIGNATURE Shane H. Powers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
MAY 26 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03377

## CERTIFICATE OF DEATH Dr Lusby

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penn		b. COUNTY Perry	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 3 Mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newport		d. STREET ADDRESS 416 Market st	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Conv Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DAVID		First ALBERT		Middle DOWNIN		4. DATE OF DEATH March 31 1957 19	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 3 1875	
9. AGE (In years on birthday) 82 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bridge Engineer		11. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co		12. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Charles Downin		14. MOTHER'S MAIDEN NAME Elizabeth Hause		15. CITIZEN OF WHAT COUNTRY? USA		Address Edwin C. Downin 1390 Penna Ave	
16. SOCIAL SECURITY NO. 178-03-6780 A		17. INFORMANT Hagerstown Ed.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1957	
19. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20b. ADDRESS (Street, city or town, state) 236 W Potomac		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20b. ADDRESS (Street, city or town, state) 236 W Potomac		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 15</u> , 1956, to <u>31 Mar</u> , 1957, that I last saw the deceased alive on <u>31 Mar</u> , 1957, and that death occurred at <u>7:45 P.M.</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>FF Lusby</u>						ADDRESS (Street, city or town, state) Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/3/57		22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown		ADDRESS Hagerstown		24a. REC'D BY REGISTRAR Apr 3, 1957		24b. REGISTRAR'S SIGNATURE James H. Gowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU X. L

APR 4 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

Dr. Wells 03378

03371

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		b. COUNTY <b>Washington</b>	
c. LENGTH OF STAY IN 1b <b>35 Yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>406 West Wilson Blvd</b>		d. STREET ADDRESS <b>406 West Wilson Blvd</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ROBERT LEE DOWNIN</b>		First	Middle
		Last	
4. DATE OF DEATH <b>March 1 1957</b>		Month	Day
		Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 27 1877</b>
			9. AGE (in years last birthday) <b>79 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Silk Twister</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown Wash. Co Md USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles McG. Downin</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Hause</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service <b>No</b>		16. SOCIAL SECURITY NO. <b>314-09-6381</b>	
17. INFORMANT <b>Nora M. Downin Hagerstown Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Arteriosclerotic hypertensive myocardial heart disease</b> DUE TO <b>445X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>none 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>
20f. (City or town) <b>—</b>		(County) <b>—</b>	
		(State) <b>—</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>S. Robert Wells</i>		DATE SIGNED <b>3-1-57</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/4/57</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Hagerstown Wash. Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K Coffman Hagerstown Md.</b>		ADDRESS	
		24a. REC'D BY REGISTRAR <b>Mar 4 1957</b>	
		24b. REGISTRAR'S SIGNATURE <b>Shatt Powers</b>	

8 V. 2

15 8



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.

VS. ATSM(E)5  
5M 9/55

03375 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Dr. Wells  
Reg. Dist. No. 302

03379

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>6 Hrs</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Wash County Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cavetown</b>		f. STREET ADDRESS <b>/</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>HENRY</b>		First <b>SETH</b>		Middle <b>FUNK</b>		4. DATE OF DEATH <b>March 7 1957</b>		Month Day Year	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 14 1888</b>		9. AGE (in years last birthday) <b>68 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Post Master</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cavetown</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va. Wash. Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>John H. Funk</b>		14. MOTHER'S MAIDEN NAME <b>Ann V. Winters</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W. V. # 1 830-34-0837</b>		17. INFORMANT <b>M. Virginia Funk Cavetown Md.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Cardiac Arrest; Coronary artery thrombosis (olu)</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>acute mesentery artery thrombosis</b> DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Low Spinal anesthesia --- died on operating table</b>									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>None 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>	
20f. (City or town) <b>-</b>		(County) <b>-</b>		(State) <b>-</b>					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <i>S. Robert Wells</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>3-8-57</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/9/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Smithsburg Cemetery</b>		22d. LOCATION (City, town, or county) <b>Smithsburg Wash. Co Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>Mar 11. 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Robert H. Bowers</b>			

BONZAU V. R.

1057

1057

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03376

## CERTIFICATE OF DEATH

03380

Reg. Dist. No. 302

1. PLACE OF DEATH o COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg Maryland	
3. NAME OF DECEASED (Type or print) First Mrs. Olytie Bender Middle Lost Gigous		4. DATE OF DEATH Month March Day 13 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Sharpsburg Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Bender		14. MOTHER'S MAIDEN NAME Annie F. Delauney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. James Wynkoop		Address Sharpsburg Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis INTERVAL BETWEEN ONSET AND DEATH 4 mos. 3 da. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Hypertensive, arteriosclerotic C.V. disease 5 Yrs. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 12, 1956, to 3/13/57, that I last saw the deceased alive on 3/12/57, 19, and that death occurred at 12:15 A.M., from the causes and on the date stated above ACTUAL SIGNATURE Walter H. Shealy M.D. ADDRESS (Street, city or town, state) Sharpsburg, Md. DATE SIGNED 3/15/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 16-57	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. View Cemetery		22d. LOCATION (City, town, or county) (State) Sharpsburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Abbott J. Williamsport, Md.		24. REC'D BY REGISTRAR REC'D. MAR. 16, 1957	
		24d. REGISTRAR'S SIGNATURE Charles H. Bowers	

BUREAU V.

JAN 19 1957

REGISTRATION

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03381

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 117 E. Washington St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEORGE		First MILTON	Middle GRIMES	4. DATE OF DEATH March	Month 7	Day 19	Year 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH January 11, 1905	9. AGE (In years from birthday) 52 yrs	10. IF UNDER 1 YEAR Months 1	11. IF UNDER 24 HRS Days 26	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Liaision Expediter		10b. KIND OF BUSINESS OR INDUSTRY Aircraft Comp ny		11. BIRTHPLACE (State or foreign country) Downsville, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Grimes		14. MOTHER'S MAIDEN NAME Pearl N. Wolford					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 214-09-0936		17. INFORMANT Maryada ric Sherry Grimes		Address Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 053.4		DUE TO Septicemia				INTERVAL BETWEEN ONSET AND DEATH 67 hours	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause if any.		(b) Deter i nate DUE TO					
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Duodenal ulcer: sub-total gastrectomy and vagotomy. 3-4-57					
20c. TIME OF INJURY Month, Day, Year Hour o. m p. m		20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Hagerstown		(County)	(State)
21. I certify that I attended the deceased from Feb. 20, 1957, to March 7, 1957, that I last saw the deceased alive on March 7, 1957, and that death occurred at 11:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Physician's NAME (Type) William T. Lavman, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/9/1957		22c. NAME OF CEMETERY OR CREMATORI Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home		ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Mar. 12, 1957		24b. REGISTRAR'S SIGNATURE Prest H. Boowers	

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1  
may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1SM 1/55

BUREAU

MAR 14 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03378

## CERTIFICATE OF DEATH

03382

Reg. Dist. No. 502

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution, residence before admission] a. STATE W. Va. b. COUNTY Berkeley ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falling Waters W. Va. RFD #1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS Marlowe W. Va.			
3. NAME OF DECEASED (Type or print)	First Clara	Middle Myrtle	Last Grove		
4. DATE OF DEATH March	Month 6	Day 19	Year 57		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 16 1880		
			9. AGE (In years less birthday) 76 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 9
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Marlowe W. Va	
13. FATHER'S NAME Samuel Landis		14. MOTHER'S MAIDEN NAME Mary Kershner		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Mr. Charles Grove Falling Waters RFD #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Cocconary Heram Basie ✓		INTERVAL BETWEEN ONSET AND DEATH 10 Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)				19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 3/6/57	(County) (State)
21. I certify that I attended the deceased from 3/5/57, 19, to 3/6/57, 19, that I last saw the deceased alive on 3/6/57, 19, and that death occurred at 9:30 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) William Street, W. Va.	
ACTUAL SIGNATURE Ralph F. Young M.D.				DATE SIGNED 3/6/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 8-57	22c. NAME OF CEMETERY OR CREMATORIUM Harmony Cemetery	22d. LOCATION (City, town, or county) Near Marlowe W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Aut. X. Z. of Williamsport, Pa.		ADDRESS		24a. REC'D BY REGISTRAR Mar. 7, 1957	24b. REGISTRAR'S SIGNATURE Joseph Boevers

HOSPITAL  ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y.

MAR 11 1957

REGISTRAR

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03383

03379

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Washington</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Frederick</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wash.-co-Hosp</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		d. STREET ADDRESS <i>405 Culler Ave</i>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Baby</i>		First <i>GIRL</i>	Middle <i>Guss</i>	Last <i>Guss</i>	4. DATE OF DEATH <i>March 17 1957</i>	Month <i>March</i>	Day <i>17</i>	Year <i>1957</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 17, 1957</i>		9. AGE (in years last birthday) yrs. <i>0</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>	13. CITIZEN OF WHAT COUNTRY <i>U.S. Maryland U.S.A.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>U.S. Government</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Bacteriologist</i>		11. BIRTHPLACE (State or foreign country) <i>Albiss. Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>			
13. FATHER'S NAME <i>Maurice Louis Guss</i>		14. MOTHER'S MAIDEN NAME <i>Florence Estell Hissom</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Vol. no. or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>111-11-1111</i>		17. INFORMANT <i>Mother</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>761.0</i>		Atelectasis		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the pre- existing cause last. (b) <i>Premature Separation of Placenta</i>		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>10 min</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>3-17, 1957, to 3-17, 1957, at 11:50 P.M.</i>							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Hagerstown</i>	(County) <i>Md.</i>	(State) <i>Md.</i>		
21. I certify that I attended the deceased from <i>3-17, 1957</i> to <i>3-17, 1957</i> , that I last saw the deceased alive on <i>3-17, 1957</i> , and that death occurred at <i>11:50 P.M.</i> from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <i>115 King St., Hagerstown, Md.</i>	
ACTUAL SIGNATURE <i>Samuel J. Woodard, M.D.</i>								DATE SIGNED <i>Mar 18 1957</i>	
PHYSICIAN'S NAME (Type) <i>Samuel J. Woodard, M.D.</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>3/18/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Rose Hill Cemetery</i>		22d. LOCATION (City, town, or county) <i>Hagerstown</i>		(State) <i>Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Inter-Parson Funeral Home Hagerstown, Md.</i>		ADDRESS <i>811-11-1111</i>		24a. REC'D BY REGISTRAR <i>Mar 18, 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Phyllis Rosewood</i>			

RECEIVED

3-13 22-3  
BUREAU Y, S

RECEIVED 11-12-57  
FBI - NEW YORK

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**(3380) MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

(13384  
302)

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Dr. WELLS

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>4 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>WASHINGTON</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL</b>		f. STREET ADDRESS <b>BROWNSVILLE</b>		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOHN - TILMAN - HAHN</b>		First	Middle	Last	4. DATE OF DEATH <b>MARCH, 11 - 1957</b>	Month	Day	Year	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER -10 - 1885</b>	9. AGE (in years last birthday) <b>71-5-1 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED EMPLOYEE OF B.T.O.B.R.CO</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BROWNSVILLE WASH. D.C. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>GEORGE WASHINGTON HAHN</b>		14. MOTHER'S MAIDEN NAME <b>LIDDY HAHN SMITH</b>		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO.</b>		16. SOCIAL SECURITY NO. <b>213 18-4386</b>		17. INFORMANT <b>MRS. BERTHA M. HAHN</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO (b)		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Benign prostatic hypertrophy with bleeding</b>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>none</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) <b>—</b>		(County) <b>—</b>	(State) <b>—</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <i>S. Robert Wells</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>3-13-57</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>									
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MARCH 14, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>CHURCH OF THE BRETHREN CEMETERY</b>		22d. LOCATION (City, town, or county) <b>BROWNSVILLE MD.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>BEST FUNERAL HOME</b>		ADDRESS <b>Boonsboro MD.</b>		24a. REC'D BY REGISTRAR <b>Other 181757</b>		24b. REGISTRAR'S SIGNATURE <b>Robert Bowers</b>			

BUREAU V. A

MAR 20 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03422

03385

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <i>Washington</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Williamsport</i>		c. LENGTH OF STAY IN 1b <i>Three 4 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Chesapeake Hospital</i>		d. STREET ADDRESS <i>Box 63</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>FANNIE</i>	Middle	Last <i>Hartie</i>	4. DATE OF DEATH <i>March 5 1957</i>	Month Day Year		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1891</i>	9. AGE (In years last birthday) <i>65 yrs</i>	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>home duties</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>home</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Edward Munson</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Saylors</i>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>	16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>Mrs. Lewis Longnecker Chewsville, Md.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Hypertension</i>		DUE TO <i>Cirrhosis - Varicose Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 years</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Cirrhosis - Varicose Disease</i>		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Hagerstown</i>	(County) <i>Hagerstown</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>2-1-1957</i> to <i>3-5-1957</i> , that I last saw the deceased alive on <i>Mar 4 1957</i> , and that death occurred at <i>211 Hagerstown</i> , M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Hagerstown, Md.</i>							
ACTUAL SIGNATURE <i>F. W. Kraiss</i>	M.D.		<i>Hagerstown, Md.</i>		DATE SIGNED <i>3/6/57</i>		
PHYSICIAN'S NAME (Type) <i>F. W. Kraiss</i>		<i>Hagerstown, Md.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>3-8-57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Rose Hill</i>	22d. LOCATION (City, town, or county) <i>Hagerstown</i>	(State) <i>Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Fred W. Kraiss</i>		ADDRESS <i>Hagerstown, Md.</i>	24a. REC'D BY REGISTRAR <i>Mar. 9, 1957</i>	24b. REGISTRAR'S SIGNATURE <i>fred. W. Kraiss</i>			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 12 1957

REGELIVE

03381 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03386  
st. No. 302

Reg. Dist. No.

**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HARFICKS TOWNSHIP</b>		c. LENGTH OF STAY IN 1b <b>24 HRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TILGHMAN TON</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASH. CO. HOSPITAL</b>			d. STREET ADDRESS <b>FAIRPLAY MD. R. I.</b>		
3. NAME OF DECEASED (Type or print) <b>NORA</b>		First <b>B</b>	Middle <b>E</b>	Last <b>HASSON</b>	4. DATE OF DEATH Month <b>MARCH</b> Day <b>19</b> Year <b>1957</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 7 1886</b>	9. AGE (in years last birthday) <b>70 8 12</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
13. FATHER'S NAME <b>CHARLIES CARNES</b>			14. MOTHER'S MAIDEN NAME <b>HARRIET DARRELL</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>NONIE CLAUDIE C. HASSON</b>		
17. INFORMANT <b>CHARLIES CARNES</b>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture lt. femur (closed)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <b>903.0</b> (b) <b>Pulmonary artery Thrombosis</b> DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Asthma</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Slapped on floor at home</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>Slapped on floor at home</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>9</b> a.m. <b>Mar 11 1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>at home</b>	
20f. (City or town) <b>Rural- Fairplay Wash. Md.</b>		(County) <b></b>		(State) <b></b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>S. Robert Wells</b>			DATE SIGNED <b>3-20-57</b>		
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MARCH 21 1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>MANOR CEMETERY Boonsboro MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>BEST FUNERAL HOME Boonsboro MD.</b>		22d. LOCATION (City, town, or county) <b>NEAR TILGHMAN TON WASH. CO. MD.</b>		(State)	
24a. REC'D BY REGISTRAR <b>Mar. 22 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Staff, Success</b>			

VS. A15ME(5)  
5M 9/55

MEAU V. S.

APR 22 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

03382

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b RURAL and give nearest town <b>Washington Co. Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md</b>		b. COUNTY <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Co. Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Spencerville</b>		d. STREET ADDRESS <b>2715 Sparrow St. Rd</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Memer</b>		First <b>Clyde</b>	Middle <b>Clyde</b>	Last <b>Hayden</b>	4. DATE OF DEATH <b>May 29, 1894</b>	Month <b>6</b>	Day <b>29</b>	Year <b>1894</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 29, 1894</b>	9. AGE (In years from birthday) <b>62</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>	13. IF UNDER 24 HRS Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SHIP CONSTR.</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>W. M. HAYDEN</b>		14. MOTHER'S MAIDEN NAME <b>GEORGIA FORD</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or <u>None</u> ) <b>Yes</b>		16. SOCIAL SECURITY NO <b>W.W.I 246-10-2771</b>		17. INFORMANT <b>Alpha M. Hayden - Sonne</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute intestinal obstruction & strangulation		INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 days</b>			
		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		+ perforation of ileum					
		(b) DUE TO		Intestinal obstrus. was extreme lymphadenitis		Unknown			
		(c)							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		Pulmonary tuberculosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from alive on <b>3/4, 1957</b> , to <b>3-4, 1957</b> , that I last saw the deceased and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above.		3/1, 1957, to 3-4, 1957		154 West <b>ADDRESS (Street, city, or town, state)</b>		DATE SIGNED <b>3:4:57</b>			
ACTUAL SIGNATURE <b>John N. Hornbaker, M.D.</b>									
PHYSICIAN'S NAME (Type) <b>John N. Hornbaker, M.D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/8/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>ROUND OAK Cemetery</b>		22d. LOCATION (City, town, or county) <b>Catoctin Co., VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John B. Bradley, Randolph, MD.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>MAR 8 1957</b>		24b. REGISTRAR'S SIGNATURE <b>John H. Bowes</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached to use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MAR 6 1957

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**03423 CERTIFICATE OF DEATH**

Reg. Dist. No. 03388

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mountain Lock		c. LENGTH OF STAY IN 1b 41 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mountain Lock	
3. NAME OF DECEASED (Type or print) CLARA		d. STREET ADDRESS Harpers Ferry Road	
First MIDDLE Last		4. DATE OF DEATH March 11 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Aug. 11, 1915	9. AGE (in years last birthday) 41 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
10c. BIRTHPLACE (State or foreign country) Mountain Lock, Md.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Harry William Otzelberger		14. MOTHER'S MAIDEN NAME Ellie Margaret Drenner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT None 214-09-5782 Rob't. D. Holbrunner	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  ix DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.  (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb-1</u> , 1957, to <u>March 11</u> , 1957, that I last saw the deceased alive on <u>March 10</u> , 1957, and that death occurred at <u>Noon</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE G. William		ADDRESS (Street, city or town, state) Baltimore, Md. DATE SIGNED 3/12/57	
PHYSICIAN'S NAME (Type) G. William		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 3/13/57		22c. NAME OF CEMETERY OR CREMATORIAL Mountain View Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE Donald E. Zwickles		24a. REC'D BY REGISTRAR Harpers Ferry, West Va.	
		24b. REGISTRAR'S SIGNATURE D. E. Zwickles	

BUKANU V. S.  
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**HOSPITAL ATTENDING PHYSICIAN:** This law requires that the death certificate be executed within 24 hours after death; "age" may be resigned by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03383

Item 11

## CERTIFICATE OF DEATH

03389

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Jackson Nursing Home</b>		e. STREET ADDRESS <b>704 Oak Hill Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Cecelia Ann Horst</b>		4. DATE OF DEATH <b>March 23 1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 11, 1871</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
10c. BIRTHPLACE (State or foreign country) <b>Roxbury, Pa.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William Miller</b>		14. MOTHER'S MAIDEN NAME <b>Lydia Franklin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT <b>Miss Mildred Brehm Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p.m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 1 1951</b> to <b>Mar 23 1957</b> , that I last saw the deceased alive on <b>Mar 23 1957</b> , and that death occurred at <b>8:10 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L L PAGKER JR</b>		ADDRESS (Street, city or town, state) <b>145 W Washington St Hagerstown Md.</b>	
PHYSICIAN'S NAME (Type) <b>L L PAGKER JR</b>		DATE SIGNED <b>3/23/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-25-57</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>Mar 25, 1957</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Scott F. Minnich &amp; Son Hagerstown Md.</b>	

BUREAU V.

MAR 27 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03390

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived) b. STATE <b>MARYLAND</b>		If institution: Residence before admission b. COUNTY <b>WASHINGTON</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOONSBORO</b>		c. LENGTH OF STAY IN 1b <b>6 MONTHS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>REFEEDER NURSING HOME</b>		d. STREET ADDRESS <b>BOONSBORO MD. R. 2.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First <b>CATHERINE</b>	Middle <b>M.</b>	Last <b>HUGHES</b>	4. DATE OF DEATH	Month <b>MARCH</b>	Day <b>4</b>	Year <b>1957</b>				
S. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 6, 1870</b>	9. AGE (In years less birthday) <b>86-11-28</b>	IF UNDER 1 YEAR Months <b>8</b>	IF UNDER 24 HRS Days <b>11</b>	Hours <b>28</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>SECURITY WASH. CO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>DANIEL WOLF</b>								14. MOTHER'S MAIDEN NAME <b>MARGARETTE LICKTY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO <b>NONE</b>		17. INFORMANT <b>PAUL E. HUGHES</b>		Address <b>HAGERSTOWN MD. R. 4</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis</b>								INTERVAL BETWEEN ONSET AND DEATH			
450.0 Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Boonsboro</b>		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>Mar. 2</b> , 1957, to <b>March 4</b> , 1957, that I last saw the deceased alive on <b>March 2</b> , 1957, and that death occurred at <b>11 P.M.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>G. W. LeVan</b>								ADDRESS (Street, city or town, state) <b>Boonsboro</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MARCH 8, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>FAHRNEYS CEMETERY NEAR MADLEVILLE WASH. CO. MD.</b>		22d. LOCATION (City, town, or county) (State)					
23. FUNERAL DIRECTOR'S SIGNATURE <b>BAST FUNERAL HOME Boonsboro MD.</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>Mar. 8, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>John H. Bast</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V.

MAR 11 1957

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Dr Wells 03391  
 Reg. Dist. No. 303

03384

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 2 Hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 410 No Locust St	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) NANCY	First	Middle LEE	Last HULL	4. DATE OF DEATH March 30 1957	Month March	Day 30	Year 19
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 17 1936	9. AGE (In years last birthday) 20 yrs.	IF UNDER 1YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Hills Toy Store		11. BIRTHPLACE (State or foreign country) Md. Chewsville Wash. Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Keller Buhrman		14. MOTHER'S MAIDEN NAME Edith Bond					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 317-32-6404		17. INFORMANT Terry D. Hull 410 No Locust St		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 476X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Gun Shot wound thru abdomen ( hemorrhage and shock)				INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Shot self with .27 rifle					
20c. TIME OF INJURY Hour 3:00 p.m.		Month, Day, Year 3-30 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at home	20f. (City or town) Hagerstown	(County) Wash.	(State) Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>S. Robert Wells</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 4-1-57		
EXAMINER'S NAME (Type) S. Robert Wells, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/2/57	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash. Co Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS		24a. REC'D BY REGISTRAR Apr 2, 1957	24b. REGISTRAR'S SIGNATURE <i>Frank Gowers</i>		

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03385 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03392

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	W. COUNTY Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	d. STREET ADDRESS 1400 Oak Hill Ave
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

3. NAME OF DECEASED (Type or print)	First JOHN	Middle FREDERICK	Last JENKINS	4. DATE OF DEATH Month March 25, 1957	Day 19	Year 19
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 14 1872	9. AGE (in years last birthday) 84 yrs.	10. IF UNDER 1 YEAR, Months Days	11. IF UNDER 24 HRS., Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Desk Clerk	10b. KIND OF BUSINESS OR INDUSTRY Dagnar Hotel	11. BIRTHPLACE (State or foreign country) Morris Run Tioga Co Pa	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME Thomas E. Jenkins	14. MOTHER'S MAIDEN NAME Ann Davis
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs Ruth Yeater 1400 Oak Hill Ave Hagerstown Md.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Advanced generalized vascular arteriosclerosis	
DUE TO Acute coronary occlusion	
Conditions, if any, which gave rise to immediate cause (b)	
DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None
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20c. TIME OF INJURY Hour e. m. p. m.	Month, Day, Year None 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) —	(County) —	(State) —
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21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>						
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ACTUAL SIGNATURE <i>S. Robert Welle, M.D.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED Mar. 27 '57
EXAMINER'S NAME (Type) S. Robert Welle, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/29/57	22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery	22d. LOCATION (City, town, or county) Hagerstown Wash. Co. Md.	(State)
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23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Cofman Hagerstown, Md.	ADDRESS	24a. REC'D BY REGISTRAR Mar. 29 1957	24b. REGISTRAR'S SIGNATURE Blast Powers
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BUREAU V. S.

APR 1 1957

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr Novenstein

03393

03425

## CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH a. COUNTY "Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Williamsport R # 2		c. LENGTH OF STAY IN 1b 50 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport R # 2				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION near Wilsons				d. STREET ADDRESS near Wilsons		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) BENJAMIN		First	Middle	Last	4. DATE OF DEATH March 26 1957	Month	Day	Year 19
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec 12 1868	9. AGE (In years last birthday) 88 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Retired		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Wilson's Wash. Co Md		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Richard Johnson				14. MOTHER'S MAIDEN NAME Sarah Dittlow				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Arthur B. Johnson 1607 Dual Highway		Address Hagerstown Md		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arterio-pulmonary heart d.</i> DUE TO 42.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertensive Cards - vascular d.</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home (City or town) Hagerstown (County) Maryland (State)				
21. I certify that I attended the deceased from <i>March 26, 1957</i> , to <i>March 26, 1957</i> , that I last saw the deceased alive on <i>March 5, 1957</i> , and that death occurred at <i>4 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sidney Novenstein M.D. Hagerstown Md.								
DATE SIGNED 3-27-57								
ACTUAL SIGNATURE SIDNEY NOVENSTEIN		DATE SIGNED 3-27-57						
PHYSICIAN'S NAME (Type) SIDNEY NOVENSTEIN								
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/28/57		22c. NAME OF CEMETERY OR CREMATORIUM St Pauls Cemetery near Clear Spring Wash Co Md		22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		24a. REC'D BY REGISTRAR DATE 1957 3-28-1957						
		24b. REGISTRAR'S SIGNATURE Lorraine McElroy						

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BUREAU V. S.

MAR 28 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2-45 N. BROAD ST.

HALFERTOWN  
MD.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

03394

Reg. Dist. No. 302

03386

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>2 WEEKS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROHRERSVILLE</b>		d. STREET ADDRESS <b>/</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASH. CO. HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>KEEDY</b>		First <b>KEEDY</b>	Middle <b></b>	Last <b>KEEDY</b>	4. DATE OF DEATH <b>MARCH - 6 1957</b>	Month <b>MARCH</b>	Day <b>6</b>	Year <b>1957</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JANUARY - 14 - 1864</b>		9. AGE (In years lost birthday) <b>93 - 1/2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>ROHRERSVILLE WASH. CO. MD. U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>ROHRERSVILLE MD.</b>			
13. FATHER'S NAME <b>JOHN A. MILLENDOIRE</b>				14. MOTHER'S MAIDEN NAME <b>SUSAN BEALER</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. ERNEST YOUNG</b>		Address <b>ROHRERSVILLE MD.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cancer of Rectum</b> DUE TO <b>154X</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Senility</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>KEEDYSVILLE</b>		(County) <b>WASH. CO.</b>	(State) <b>MD.</b>
21. I certify that I attended the deceased from <b>19</b> to <b>3 - 6</b> <b>1957</b> that I last saw the deceased alive on <b>3 - 6</b> <b>1957</b> , and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>J R Dwyer</i>		ADDRESS (Street, city or town, state) <b>Hegeman St. Mt.</b>							
PHYSICIAN'S NAME (Type) <b>Dwyer</b>		DATE SIGNED <b>12/1957</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MARCH 10 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>FAIRVIEW CEMETERY</b>		22d. LOCATION (City, town, or county) <b>KEEDYSVILLE WASH. CO. MD.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PAST FUNERAL HOME Boonsboro MD</b>		ADDRESS <b>Boonsboro MD</b>		24a. REC'D BY REGISTRAR <b>Mar. 12 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Chart, Dowers</b>			

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03426

03395

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro		c. LENGTH OF STAY IN 1b Reeder Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Reeder Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Daniel	Middle Ralph	Last Kepler	4. DATE OF DEATH 3	Month 19	Day 19	Year 1957		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/5/1896	9. AGE (In years last birthday) 60 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm owner		10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Daniel Kepler				14. MOTHER'S MAIDEN NAME Martha Jane Derr					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-36-6496		17. INFORMANT Mrs. Charles Leatherman, Liddletown, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				Gastroenteritis Acute pyonephrosis		INTERVAL BETWEEN ONSET AND DEATH 16 yrs. 5 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Boonsboro	(County)	(State)			
21. I certify that I attended the deceased from <u>Oct 1</u> , 1956 to <u>March 19</u> , 1957, that I last saw the deceased alive on <u>March 18</u> , 1957, and that death occurred at <u>Boonsboro</u> , Md., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Boonsboro									
ACTUAL SIGNATURE <i>G.W. LeVan</i>	DATE SIGNED 3/20/57								
PHYSICIAN'S NAME (Type) Dr. Gerald W. LeVan	M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/21/1957	22c. NAME OF CEMETERY OR CREMATORIUM Lutheran Cemetery	22d. LOCATION (City, town, or county) Middletown, Md.	(State)					
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co., Middletown, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE May 22, 1957	24b. REGISTRAR'S SIGNATURE <i>John H. Reid</i>						

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03397

## CERTIFICATE OF DEATH

Reg. Dist. No.

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**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b>			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>13 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>			d. STREET ADDRESS <b>751 S. Potomac St.</b>			
3. NAME OF DECEASED (Type or print) <b>John</b>		First <b>Ervin</b>	Middle <b>Lewis</b>	4. DATE OF DEATH <b>March 18</b>	Month <b>March</b> Day <b>18</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4, 1880</b>	9. AGE (In years less birthday) <b>71 76 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>		11. BIRTHPLACE (State or foreign country) <b>Foxville Md.</b>		
13. FATHER'S NAME <b>Alfred Lewis</b>			14. MOTHER'S MAIDEN NAME <b>Rebecca Kuhn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>213-18-0827</b>		17. INFORMANT <b>Mrs. Carrie V. Lewis</b>	Address <b>Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Employer &amp; pneumonia</b> DUE TO <b>527.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>-----</b> DUE TO <b>-----</b> (c) <b>gout arterioscler</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>136 North Potomac Street</b>	(County) <b>Hagerstown</b> (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>2/27/57</b> , 19____, to <b>3/18/57</b> , 19____, that I last saw the deceased alive on <b>3/18/57</b> , 19____, and that death occurred at <b>6:50 p.m.</b> , from the causes and on the date stated above. (ADDRESS (Street, city or town, state) <b>136 North Potomac Street</b> DATE SIGNED <b>3/19/57</b>						
ACTUAL SIGNATURE <b>Howard N. Weeks, M.D.</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-21-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) <b>Hagerstown</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>			ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>Mer. 21, 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Howard N. Weeks</b>

RECEIVED  
MAR 29 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04555

03389

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
WASHINGTON MARYLAND		b. COUNTY MARYLAND WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 6 WEEKS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH. Co. HOSPITAL		e. STREET ADDRESS Boonsboro LAKIN AVENUE	
3. NAME OF DECEASED (Type or print) FLORA		First	Middle
4. DATE OF DEATH		Month	Day
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH
MALE		WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> JULY-14-1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
HOUSE KEEPER		OWN HOME	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
NEAR Boonsboro WASH. CO. MD. U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
THOMAS LINE		MALINDA TOME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) <input type="checkbox"/> NO		16. SOCIAL SECURITY NO.	
		17. INFORMANT	
		NONE FRANK LINE 616 W. FRANKLIN ST. HAGERSTOWN MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 4</u> , 1957, to <u>March 31</u> , 1957, that I last saw the deceased alive on <u>March 30</u> , 1957, and that death occurred at <u>Neon M.</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Boonsboro	
ACTUAL SIGNATURE <u>G. W. Bevan</u>		DATE SIGNED 4/2/57	
PHYSICIAN'S NAME (Type) G. W. Bevan		22d. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
22b. DATE THEREOF APRIL-4-1957		22c. NAME OF CEMETERY OR CREMATORIUM Boonsboro CEMETERY	
23. FUNERAL DIRECTOR'S SIGNATURE BAPT FINANCIAL HOME		22d. LOCATION (City, town, or county) Boonsboro WASH. CO. MD.	
ADDRESS Boonsboro MD.		24a. REG'D BY REGISTRAR Apr. 6, 1957	
		24b. REGISTRAR'S SIGNATURE Baptist Boonsboro	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y.

APR 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr Jennings

03398

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Hagerstown		c. LENGTH OF STAY IN 1b 24 Hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 623 George St		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) EMMA		First	Middle	Losl	4. DATE OF DEATH Mar 19 1957	Month	Day	Year 19
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec 13 1888	9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Knitter		10b. KIND OF BUSINESS OR INDUSTRY Hosiery Mills		11. BIRTHPLACE (State or foreign country) Edgemont Wash. no		12. CITIZEN OF WHAT COUNTRY? Md. USA		
13. FATHER'S NAME Edward Kriner		14. MOTHER'S MAIDEN NAME Florence Sell						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO 214-09-8179		17. INFORMANT Mrs Margaret Barrow		Address 623 George St Hagerstown Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		B. Bronchopneumonia, bilateral				INTERVAL BETWEEN ONSET AND DEATH 3 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Mitral and Aortic Stenosis, severe. Pulmonary Emphysema.						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown		(County) (State)
21. I certify that I attended the deceased from 3/15 1957, to 3/19 1957, that I last saw the deceased alive on 3/19 1957, and that death occurred at 2:20 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) M.D. 136 W. Washington St. Hagerstown, Md.		DATE SIGNED 3/20/57
ACTUAL SIGNATURE George Jennings		PHYSICIAN'S NAME (Type) George Jennings						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/21/57		22c. NAME OF CEMETERY OR CEMETORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash. no Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS		24a. REC'D BY REGISTRAR Mar 23/57		24b. REGISTRAR'S SIGNATURE George Jennings		

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AR 26 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18										03399			
CERTIFICATE OF DEATH										Dr Ditto			
										Reg. Dist. No. 302			
03391					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)								
1. PLACE OF DEATH a. COUNTY Washington					STATE Maryland					STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					c. LENGTH OF STAY IN 1b 10 Min					CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Court House					d. STREET ADDRESS -----					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First GEORGE		Middle WILSON		Last LOUDENSLAGER		4. DATE OF DEATH March 21 1957		Month 19	Day 19	Year 19	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Feb 19 1901		9. AGE (In years lost birthday) 56 yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY J. B. Ferguson Co.		11. BIRTHPLACE (State or foreign country) Md. Hagerstown Wash. Co.		12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Loudenslager						14. MOTHER'S MAIDEN NAME Emma Wilson							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. 241-09-4055		17. INFORMANT Virginia F. Loudenslager		Address R # 2 Md Hagerstown			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. } (b) <i>existing, chronic heart disease</i> 1/3/56 DUE TO (c) 3/24/57													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown		(County) Md.		(State) Md.			
21. I certify that I attended the deceased from 1/2-3-1956, to 3-21-1957, that I last saw the deceased alive on 3-14-1957, and that death occurred at 10:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL <i>h. E. Ditto</i> M.D. <i>Hagerstown Md</i> DATE SIGNED <i>3/24/57</i> PHYSICIAN'S NAME (Type) <i>Dr W. Ditto</i> <i>Hagerstown Md</i> <i>3/24/57</i>													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/24/57		22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash. Co. Md		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.						24a. REC'D BY REGISTRAR Mar. 25 1957 <i>Robert Beavers</i> 24b. REGISTRAR'S SIGNATURE							

RECEIVED V. S.

MAR 27 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03400

03392

## CERTIFICATE OF DEATH

Reg. Dist. No. B02

1. PLACE OF DEATH o COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE I'd. F rederick b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Smithsburg			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Smithsburg		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital			d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Lueilla	Middle Irene	Last Lovell	4. DATE OF DEATH March 10, 1957	Month Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/11/1888	9. AGE (In years lost birthday) 66 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY U.S.
13. FATHER'S NAME Josiah Smith			14. MOTHER'S MAIDEN NAME Ellen Fox		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. none	17. INFORMANT J. Floyd Lovell, Smithsburg, I'd.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease</i>			INTERVAL BETWEEN ONSET AND DEATH 2 mos.		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Myocardial infarction</i>			2 day.		
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hagerstown	(County) (State)
21. I certify that I attended the deceased from <u>Mar. 9</u> , 1957, to <u>Mar. 10</u> , 1957, that I last saw the deceased alive on <u>Mar. 10</u> , 1957, and that death occurred at <u>111 P. M.</u> from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) <u>M.D. 170 W. Washington St</u> DATE SIGNED <u>Mar. 13, 1957</u>					
ACTUAL SIGNATURE <u>R. S. Stauffer</u> PHYSICIAN'S NAME (Type) <u>R. S. STAUFFER</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/12/1957	22c. NAME OF CEMETERY OR CREMATORIAL Garfield E. U. P. Cem.	22d. LOCATION (City, town, or county) Frederick Co., Md	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co., Huddletown, Md.			24a. REC'D BY REGISTRAR Mar. 13, 1957	24b. REGISTRAR'S SIGNATURE R. S. Stauffer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
BUREAU V. S.

MAR 15 1957

## MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

03401

03393

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		b. COUNTY <b>Washington</b>			
c. LENGTH OF STAY IN 1b <b>40 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>139 Randolph Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Lillie</b>	Middle <b>May</b>	Last <b>Lum</b>		
4. DATE OF DEATH	Month <b>March</b>	Day <b>22</b>	Year <b>19 57</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 11, 1900</b>		
9. AGE (In years last birthday) <b>56 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>			
11. BIRTHPLACE (State or foreign country) <b>Steelton, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b></b>			
13. FATHER'S NAME <b>William C. Fish</b>		14. MOTHER'S MAIDEN NAME <b>Ida C. Turpin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-28-8091</b>			
17. INFORMANT <b>Mrs. Clara Bonney, Hagerstown, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of uterus</b>			
DUE TO <b>Metastasis to liver (jaundice &amp; ascites)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		lyr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			
20c. TIME OF INJURY Hour o. g. p. m. <b>None</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	20f. (City or town) <b>-</b>	(County) <b>-</b>	(State) <b>-</b>
21. I certify that I attended the deceased from <b>Oct. 19 46</b> to <b>March 22, 1957</b> , that I last saw the deceased alive on <b>March 22, 1957</b> , and that death occurred at <b>10:15 P.M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>S. Robert Wells</b>				ADDRESS (Street, city or town, state) <b>115 N. Potomac St., Hagerstown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Samuel Wells, M.D.</b>				DATE SIGNED <b>3-23-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>3-26-57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) <b>Hagerstown, Md.</b>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>			24. REC'D BY REGISTRAR <b>Mar 26, 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Chas H. Boevers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

RECEIVED  
BUREAU V.

MAR 28 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03402

03394

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>32 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>Hag. Rt. 5</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>James</b>	Middle <b>Roy</b>	Last <b>Magaha</b>	4. DATE OF DEATH	Month <b>March</b>	Day <b>20</b>	Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 10, 1890</b>	9. AGE (In years less birthday) <b>66</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>refrigeration</b>		11. BIRTHPLACE (State or foreign country) <b>Sheperdstown, W.Va.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Henry Magaha</b>		14. MOTHER'S MAIDEN NAME <b>Jennie</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-5883</b>	
17. INFORMANT <b>Mrs. Glenn Magaha, Hagerstown Rd 5, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis</b>		19. INTERVAL BETWEEN ONSET AND DEATH <b>3 days.</b>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <b>Arteriosclerosis</b>		DUE TO (b)		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Hagerstown</b>	(County)	(State)
21. I certify that I attended the deceased from <b>Sept 27, 1954</b> to <b>March 20, 1957</b> , that I last saw the deceased alive on <b>March 20, 1957</b> , and that death occurred at <b>123</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Boyer</b>		M.D.		ADDRESS (Street, city, or town, state) <b>135 N. Potomac St., Hagerstown, Md.</b>		DATE SIGNED <b>3/22/57</b>	
PHYSICIAN'S NAME (Type) <b>David J. Boyer, M.D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>					
22b. DATE THEREOF <b>3-23-57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Hagerstown, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>Mar. 25, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. Gowers</b>	

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 27 1957

REGELIVE

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
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 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03403

03395

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None 309 Radcliffe Avenue		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
3. NAME OF DECEASED (Type or print) Clarence		First Edgar	Middle McCarren
4. DATE OF DEATH Mar.	Month Mar.	Day 31	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-19-1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Concrete Mixing		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Emmitsburg, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles McCarren		14. MOTHER'S MAIDEN NAME Josephine Eckenrode	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None	
17. INFORMANT None		Address Mrs. C. E. McCarren, Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 31X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		INTERVAL BETWEEN ONSET AND DEATH Minutes Cardiovascular collapse	
(b) DUE TO General Vascular Accident		5 days	
(c) Arteriosclerosis		4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 24, 1957</u> , to <u>Mar. 21</u> , 1957, that I last saw the deceased alive on <u>Mar. 30</u> , 1957, and that death occurred at <u>12 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. <u>1195 Chestnut St. 7-1211</u> DATE SIGNED ACTUAL SIGNATURE <u>Louis G. Goff</u> PHYSICIAN'S NAME (Type) <u>Louis G. Goff</u> Hagerstown MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-2-1957	
22c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Touzer Funeral Home R. Franklin Parker		ADDRESS Hagerstown, Maryland	
24a. RECD BY REGISTRAR Apr. 4, 1957		24b. REGISTRAR'S SIGNATURE Chas. Boekele	

BUREAU V. S

APR 8 1957

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03404

03396

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 59 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1802 Virginia Avenue				d. STREET ADDRESS 1802 Virginia Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF <del>DECEASED</del> (Type or print)		First Lawrence	Middle Edward	Last McClain	4. DATE OF DEATH Mar.	Month Mar.	Day 21	Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8-20-1897	9. AGE (In years less birthday) 59 yrs	10. IF UNDER 1 YEAR/IF UNDER 24 HRS Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Money Order Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Daniel S. McClain		14. MOTHER'S MAIDEN NAME Ellen Lushbaugh							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. N.E.		17. INFORMANT Mrs. Lawrence McClain, a, 1802 Virginia Avenue, Hagerstown, Maryland		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) 180X DUE TO (c)		Carcinoma - Rt Kidney - Recurrent Metastatic				INTERVAL BETWEEN ONSET AND DEATH 1 yr.			
DUE TO Diabetes Mellitus (b) DUE TO (c)						6 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown		(County)	(State)
21. I certify that I attended the deceased from <u>Oct 16, 1957</u> to <u>Death 21, 1957</u> , that I last saw the deceased alive on <u>March 19, 1957</u> , and that death occurred at <u>7 M.</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Philip J. Holman</i>		ADDRESS (Street, city or town, state) M.D. 159 W. Washington Street, Hagerstown, Maryland						DATE SIGNED <u>3/21/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-24-1957		22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Franklin Bowers</i>		ADDRESS 305 North 1st St.		24a. REC'D BY REGISTRAR Mar. 22, 1957		24b. REGISTRAR'S SIGNATURE <i>John Franklin Bowers</i>			

**HOSPITAL OR ATTENDING PHYSICIAN:** This law requires that the death certificate be executed within 24 hours after death. Log in  
may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGAIVE

APR 3 1957

PUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 File No. 3-25-57 at

03405

03397

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE		Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY		Wash.		
Hagerstown		3½ years		Hagerstown				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Garlock Nursing Home				50 East Ave.,		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month	Day	Year	
Nora		M	McKee	July	8	8	19 57	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost by day)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS		
female	white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	July 8, 1863	94 yrs.	Months	Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
retired		school teacher		Ohio		USA		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				
Henry Axline				Elizabeth Younker				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT		Address		
no		none		Mrs. Grover McHenry		Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)								
Arterio-sclerotic Heart Disease 3 yrs.								
4-0-0 DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)								
Arterio-sclerosis - Generalized 7 yrs.								
DUE TO								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
Rheumatoid Arthritis - 30 yrs. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 1942 to Mar. 8, 1957, that I last saw the deceased alive on Mar. 8, 1957, and that death occurred at 12 M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state)								
DATE SIGNED								
ACTUAL SIGNATURE								
Lloyd A. Hoffman M.D. 214 N. Potomac St. 3/9/57								
PHYSICIAN'S NAME (Type)								
Lloyd A. Hoffman Hagerstown, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORI		22d. LOCATION (City, town, or county)		
burial		3-11-57		Lutheran		Lovettsville		
(State) Va.								
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS				
Fred W. Kraiss				Hagerstown, Md.				
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE				
Mar. 12, 1957				B. H. B. / B. H. B. / B. H. B.				

RECEIVED  
MAR 14 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03406

03398

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 weeks		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		f. STREET ADDRESS 219 North Mulberry St.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John		First Franklin		Middle Miles		4. DATE OF DEATH Mar. 3 1957		Month Day Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> August 1, 1983		9. AGE (In years from birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 7 Days 2 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mech. Maintenance Man		10b. KIND OF BUSINESS OR INDUSTRY Aircraft Company		11. BIRTHPLACE (State or foreign country) Washington County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Daniel Miles		14. MOTHER'S MAIDEN NAME Amanda Catherine Bowers							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-16-0130		17. INFORMANT Mary V. Miles, Hagerstown, Maryland		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 610X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Uremia DUE TO (c) Prostate Hypertrophy						INTERVAL BETWEEN ONSET AND DEATH 12 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) —		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) —		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 27, 1956, to March 3, 1957, that I last saw the deceased alive on March 3, 1957, and that death occurred at 3 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE J. G. Warden, M.D.						ADDRESS (Street, city or town, state) 832 Potomac Ave., Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-5-1957		22c. NAME OF CEMETERY OR CREMATORIAL St. Paul Cemetery		22d. LOCATION (City, town, or county) St. Paul, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Bowers Superior Funeral Home		ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Mar 5, 1957		24b. REGISTRAR'S SIGNATURE John H. Bowers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SAVILLE V. S.

MAR 7 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03399

## CERTIFICATE OF DEATH

03407  
302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2. City town			b. COUNTY Washington		
c. LENGTH OF STAY IN 1b 70 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3. Hagerstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 910 Potowac Avenue			d. STREET ADDRESS 610 Potowac Avenue		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Daniel		First	Middle	Last	4. DATE OF DEATH Mar. 19 1957
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8-2-1861	9. AGE (In years at last birthday) 92 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dry Goods buyer		10b. KIND OF BUSINESS OR INDUSTRY Eyerly's Dept.		11. BIRTHPLACE (State or foreign country) Sharpsburg, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Michael Miller			14. MOTHER'S MAIDEN NAME Christain Schindel		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. WCE		
17. INFORMANT Mrs. John McKee, Hagerstown, Maryland			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 570.2 Mesenteric thrombosis			INTERVAL BETWEEN ONSET AND DEATH 5 days		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			Indefinite		
(b) Generalized arteriosclerosis					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Feb. 19, 1957, to March 19, 1957, that I last saw the deceased alive on March 18, 1957, and that death occurred at 1 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 148 West Washington Street DATE SIGNED 3/19/57					
ACTUAL SIGNATURE B. B. Kneisley		PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-21-1957		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery	
22d. LOCATION (City, town, or county) Hagerstown, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE After day, 7 in a.m. Hagerstown, Maryland		ADDRESS		24a. REC'D BY REGISTRAR Mar. 22, 1957	
				24b. REGISTRAR'S SIGNATURE B. B. Kneisley	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
MAR 03 1957

LIBRARY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03400

## CERTIFICATE OF DEATH

13408

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1924 Virginia Ave.		e. STREET ADDRESS 1924 Virginia Ave.				
3. NAME OF DECEASED (Type or print) Bessie Florence Moats		4. DATE OF DEATH March 17 1957	Month Day Year			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> April 1 1881	9 AGE (In years last birthday) 75 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook Restaurant	11. KIND OF BUSINESS OR INDUSTRY Restaurant	12. BIRTHPLACE (State or foreign country) Fairplay Md.	13. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Hamilton Miller		14. MOTHER'S MAIDEN NAME Martha Wade		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For, no, or unknown) No		
16. SOCIAL SECURITY NO 215-14-101		17. INFORMANT Mr. Harry T. Moats		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/17/57 19 to 3/17/57 19, that I last saw the deceased alive on 3/17/57 19, and that death occurred at 6 A.M. from the causes and on the date stated above.		ACTUAL SIGNATURE Ralph F. Young M.D.		ADDRESS (Street, city or town, state) Williamport, Md. DATE SIGNED 3/18/57		
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF March 20-57		22c. NAME OF CEMETERY OR CREMATORIUM Manor Cemetery		22d. LOCATION (City, town, or county) Near Tilghmanton Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Albert Leff Williamsport, Md.		ADDRESS 191957		24a. REC'D BY REGISTRAR Alice Powers		24b. REGISTRAR'S SIGNATURE Albert Leff Williamsport, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
BUREAU V. S.

MAR 20 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 -  $\frac{1}{2} \times \frac{1}{2} = \frac{1}{4}$

03409

302

Reg. Dist. No.

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**○ FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY was in son			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland			b. COUNTY was in son		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 40 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital						d. STREET ADDRESS 339 North Mulberry Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Carl		First	Middle	Last	4. DATE OF DEATH Mar. 21 1957	Month	Day	Year			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2-22-1896	9. AGE (In years lost birthday) 61 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours	13. Months	14. Days	15. Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Room Clerk		10b. KIND OF BUSINESS OR INDUSTRY News Agency		11. BIRTHPLACE (State or foreign country) Brucetown, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Annie E. Alben								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) Yes			16. SOCIAL SECURITY NO. W.W. #1			17. INFORMANT re. Carl Moulden, Hagerstown, Maryland			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.			Acute cardiac dilatation & failure			INTERVAL BETWEEN ONSET AND DEATH 3 weeks					
(b) DUE TO			coronary sclerosis			years					
(c) DUE TO			Generalized arteriosclerosis			years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hydrothorax, Pericarditis, Congested liver									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 1b.]								
20c. TIME OF INJURY Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 21 July 1956, to 21 Mar. 1957, that I last saw the deceased alive on 21 Mar. 1957, 12, and that death occurred at 3 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Richard T. Binfard M.D. 1135 POTOMAC AVENUE, HAGERSSTOWN, MD.									DATE SIGNED		
ACTUAL SIGNATURE			PHYSICIAN'S NAME (Type) RICHARD T. BINFARD M.D.			23 MARCH 1957					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 3-25-1957			22c. NAME OF CEMETERY OR CREMATORI Resurrection Cemetery			22d. LOCATION (City, town, or county) Hagerstown, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE John F. Frankl Funeral Home			ADDRESS 305 North Potomac Street			24a. REC'D BY REGISTRAR Mar. 29, 1957			24b. REGISTRAR'S SIGNATURE John H. Bowers		

BUREAU V. S.

1957 1 Dec

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

03410

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY		03492	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)				
Washington MARYLAND		a. STATE Md.		b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 10 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Hagerstown				Williamsport			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Route 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Washington County Hospital							
3. NAME OF DECEASED (Type or print)	First J	Middle Henry	Last Myers	4. DATE OF DEATH 3	Month 20	Day 19	Year 57
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1874	9. AGE (In years last birthday) 82	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY John B Stetson Co		11. BIRTHPLACE (State or foreign country) Wash. Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Emanuel Myers		14. MOTHER'S MAIDEN NAME Sarah Shaw					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO 166-09-2056-1		17. INFORMANT Mr. A. A. Weaver		Address Williamsport, Md. R2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Anaplastic carcinoma of bladder		INTERVAL BETWEEN ONSET AND DEATH 9 mos.			
181X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO					
(c)		DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Frenia		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Williamsport		(County) (State)	
21. I certify that I attended the deceased from 7-2-1956 to 3-20-57, 1957, that I last saw the deceased alive on 3-20-57, 1957, and that death occurred at 8:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Joseph C. Crisp, M.D. DATE SIGNED 3-20-57							
PHYSICIAN'S NAME (Type) Joseph C. Crisp, M.D.		115 King St., Hagerstown, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-23-57		22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill		22d. LOCATION (City, town, or county) Hagerstown	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Mar. 22, 1957		24b. REGISTRAR'S SIGNATURE Charles H. Boward	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be retained with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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APR 30 1957

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03427

## CERTIFICATE OF DEATH

03411

Reg. Dist. No.

301

1 PLACE OF DEATH a COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 13 W. Salisbury Street		d. STREET ADDRESS 13 W. Salisbury Street	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Bessie	Middle Spickler	Last Newcomer
4. DATE OF DEATH March	Month 17	Day 19	Year 57
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W.DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5 1887
9. AGE (In years last birthday) 69 yrs	10. IF UNDER 1 YEAR Months 11	11. IF UNDER 24 HRS Days 11	12. IF UNDER 24 HRS Hours 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Williamsport Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John J. Spickler		14. MOTHER'S MAIDEN NAME Kate Bragunier	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mr. Grayson Newcomer		Address 13 W. Salisbury St Williamsport Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/16/57</u> to <u>3/17/57</u> , that I last saw the deceased alive on <u>3/17/57</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. Williamsport, Md DATE SIGNED <u>3/18/57</u>	
ACTUAL SIGNATURE <u>Ralph F. Young</u>		PHYSICIAN'S NAME (Type) Ralph F. Young M. D.	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF March 19-57	
22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		22d. LOCATION (City, town, or county) Williamsport Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Lee Williamsport, Md</u>		24a. REC'D BY REGISTRAR Dy	
ADDRESS <u>John Lee Williamsport, Md</u>		24b. REGISTRAR'S SIGNATURE <u>March 19-57 Lee McElroy</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

MAR 20 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03412

03403

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial/transit permit. Then please ~~remove carbon papers~~. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

APR 4 1967

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

03404

03412  
302

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>22 YRS.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>	
3. NAME OF DECEASED (Type or print) <b>MARTHA BARNETT POTTER</b>		4. DATE OF DEATH <b>MARCH 20 1957</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/25/1901</b>
9. AGE (In years last birthday) <b>55 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BEAUTICIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN SHOP</b>	
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM BARNETT</b>		14. MOTHER'S MAIDEN NAME <b>MARY HUSTON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-09-2103</b>	
17. INFORMANT <b>MR. JOHN E. POTTER SR.</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> INTERVAL BETWEEN ONSET AND DEATH			
DUE TO <b>420.1</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Cirrhosis of liver			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Hour o. m. <b>none</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>
(County) _____		(State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>S. Robert Wells</i>		DATE SIGNED <b>3-22-57</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/23/57</b>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>ROSE HILL CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Norment, Hagerstown, Md.</i>		24a. REC'D BY REGISTRAR <b>Mar. 25, 1957</b>	
		24b. REGISTRAR'S SIGNATURE <i>Joseph R. Powers</i>	

BUREAU V. S.

MAR 27 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03414

## 03405 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. STREET ADDRESS 210 Fairground Ave.	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MARSHALL	Middle LIELLYN	Last RICHARDSON
4. DATE OF DEATH	Month March	Day 21	Year 1957
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 5, 1887
8. AGE (In years last birthday) 69 yrs.	9. IF UNDER 1 YEAR Months 10	10. IF UNDER 24 HRS Days 16	Hours Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY Metal Working Co.	
10c. BIRTHPLACE (State or foreign country) Clearfield, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William M. Richardson		14. MOTHER'S MAIDEN NAME Eliza J. Anderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-09-0172	
17. INFORMANT Mrs. William Hoffman		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 24 days 15 yrs.	
b. DUE TO Bacterial infection			
c. DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/27/57, 19, to 3/20/57, 19, that I last saw the deceased alive on 3/20/57, 19, and that death occurred at 4:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Physician's NAME (Type) Howard N. Weeks, M.D.		136 North Potomac St. 3/22/57 Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/23/1957	22c. NAME OF CEMETERY OR CREMATORIAL Broadfording Cemetery
22d. LOCATION (City, town, or county) Broadfording, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Kouzer Funeral Home R. Franklin Bowers		24a. REC'D BY REGISTRAR Mar. 22, 1957	24b. REGISTRAR'S SIGNATURE Joseph Bowers
VS AHS [4] 15M 9/55			

RECEIVED  
MURRAY V. S.

MAR 30 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03415

03406

## CERTIFICATE OF DEATH

Reg. Dist. No. 301

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 8 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First MIDDLE LAST MARTIN N. Rohrback		4. DATE OF DEATH Month 3 Day 25 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9-30-1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		9. AGE (In years last birthday) 58 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY Power Co.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ALLEN Rohrback	
14. MOTHER'S MAIDEN NAME ALICE MECKER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 214-10-3342		17. INFORMANT Mrs. Jessie B. Humphreys	
		Address Baddock, Hagerstown - Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion		24 hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arteriosclerosis		4-5 yr	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1945 to Mar 25, 1957, that I last saw the deceased alive on Mar 25, 1957, and that death occurred at 12:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert V. Campbell M.D.		ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED 3/25/57	
PHYSICIAN'S NAME (TYPE) Robert V. Campbell M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-27-1957	
22c. NAME OF CEMETERY OR CREMATORIAL M. C. C. Cemetery		22d. LOCATION (City, town, or county) (State) Frederick - Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. C. E. Clinet Son		ADDRESS Frederick - Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Chas. H. Powers	
DATE 29 March 1957			

BUREAU V.

APR 1 1957

RECEIVED

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03407

## CERTIFICATE OF DEATH

Dr Jennings

Reg. Dist. No. 302

03416

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 Hr</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		d. STREET ADDRESS <b>Western Pike</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>MARY</b>		First	Middle	Last	4. DATE OF DEATH <b>March 31 1957</b>	Month	Day	Year <b>19</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 31 1957</b>	9. AGE (In years lost birthday) yrs <b>5</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Ralph F. Royce</b>				14. MOTHER'S MAIDEN NAME <b>Donna Baumann</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Ralph F. Royce Hagerstown Md R # 2</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Immaturity - 6 months pregnancy</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 min</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <b>136 W. Washington St. Hagerstown, Md</b> (State)		
21. I certify that I attended the deceased from <b>3/31</b> , 1957, to <b>3/31</b> , 1957, that I last saw the deceased alive on <b>3/31/57</b> , 1957, and that death occurred at <b>3:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>136 W. Washington St. Hagerstown, Md</b> DATE SIGNED <b>4/1/57</b>								
ACTUAL SIGNATURE <b>George Jennings</b>		M.D.						
PHYSICIAN'S NAME (Type) <b>George Jennings</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/1/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Hagerstown Wash. Co Md</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>		ADDRESS <b>136 W. Washington St. Hagerstown, Md</b>						
		24a. REC'D BY REGISTRAR <b>Apr. 2, 1957</b>						
		24b. REGISTRAR'S SIGNATURE <b>John H. Bowers</b>						

BUREAU V. S.

APR 4 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03417

03408

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 45 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
3. NAME OF DECEASED (Type or print) CHARLES		First MIDDLE RUSSELL	4. DATE OF DEATH MARCH 5 1957
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/25/1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LIQUOR DEALER		10b. KIND OF BUSINESS OR INDUSTRY WHOLESALE RETAIL STORE	11. BIRTHPLACE (State or foreign country) WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GEORGE W. SANBOWER	
14. MOTHER'S MAIDEN NAME LILLIE JONES		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. EVA S. SANBOWER	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Total renal shutdown, uremia, periorbital edema, 1 day DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Nephrosclerosis DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH culicic acid 1 day	
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Nodular hyperplasia of prostate	
20c. TIME OF INJURY Month. Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 9, 1956, to March 5, 1957, that I last saw the deceased alive on Mar. 5, 1957, and that death occurred at _____, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE JOSEPH C. CRISP. M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/7/57	
22c. NAME OF CEMETERY OR CREMATORIAL ROSE HILL CEM.		22d. LOCATION (City, town, or county) HAGERSTOWN (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Horowitz, Hagerstown, Md.		24a. REC'D BY REGISTRAR Mar. 8, 1957	
24b. REGISTRAR'S SIGNATURE Joseph C. Crisp			

RECEIVED  
BUREAU V. S.

MAR 11 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03418

03409

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 50 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 130 E. Franklin St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 130 E. Franklin St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Clifford		First	Middle	Last	4. DATE OF DEATH March	Month	Day	Year 1957
5. SEX Male		6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1886	9. AGE (In years last birthday) 70	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Brick Layer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Church Hill Fred Co. Md.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME David W. Schildknecht		14. MOTHER'S MAIDEN NAME Cordelia C. Paliver						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) ----		16. SOCIAL SECURITY NO. ----		17. INFORMANT Mrs Lottie Schildknecht		Address Hagerstown Md.		
18. CAUSE OF DEATH [Enter only one cause per line for, (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		Atrial Fibrillation, myocardial failure				INTERVAL BETWEEN ONSET AND DEATH 3 Mths+		
(b) DUE TO Arteriosclerotic Heart disease						10 yrs+		
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) M.D. 236 N Potomac		(County)		(State)
21. I certify that I attended the deceased from 26 Feb 1957 to 2 May 1957, that I last saw the deceased alive on 1 Mar 1957, and that death occurred at 3 AM, from the causes and on the date stated above. ACTUAL SIGNATURE F. F. Lushby						ADDRESS (Street, city or town, state) M.D. 236 N Potomac		
PHYSICIAN'S NAME (Type) F. F. Lushby						DATE SIGNED 4 Mar 57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-4-57		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR Mer 5 1957		24b. REGISTRAR'S SIGNATURE Bush Bowers		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
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DUREAU V. S.

MAR 7 1957

REGISTRATION

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
03410 Dr Lusby

03419

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maryland</b>	
c. LENGTH OF STAY IN 1b <b>6 Mos</b>		d. STREET ADDRESS <b>03 Hagerstown 639 West Washington st</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>639 West Washington</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HARRY</b>		First <b>L</b>	Middle <b>SCHUSTER</b>
4. DATE OF DEATH <b>March 14 1957</b>	Month <b>19</b>	Day <b>14</b>	Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 14 1874</b>
9. AGE (In years last birthday) <b>83 yrs</b>		10. IF UNDER 1 YEAR Months <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (State or foreign country) <b>Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Robert Schuster</b>	
14. MOTHER'S MAIDEN NAME <b>Barbara Weymer</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO <b>-----</b>		17. INFORMANT <b>Mrs Ethel C. Mowen 402 W. Washington St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Hagerstown Md. INTERVAL BETWEEN ONSET AND DEATH <b>11 yrs +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 1</b> , 1956, to <b>14 Mar</b> , 1957, that I last saw the deceased alive on <b>13 Nov</b> , 1957, and that death occurred at <b>145 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>FF Lusby</b>		ADDRESS (Street, city or town, state) <b>M.D. 230 N Platman</b>	
PHYSICIAN'S NAME (Type) <b>FF Lusby</b>		DATE SIGNED <b>15 Mar 57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/16/57</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Hagerstown Wash. Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>Mar 18 1957</b>	
		24b. REGISTRAR'S SIGNATURE <b>Frank Bowers</b>	

BUREAU V. 8

MAR 20 1957

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr Hornbaker

03420

03411

## CERTIFICATE OF DEATH

Reg. Dist. No 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>3 Yrs</b>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OR INSTITUTION <b>21 Broadway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ROLLIN PAUL SHATTO</b>		First <b>ROLLIN</b>	Middle <b>PAUL</b>
4. DATE OF DEATH <b>March 25 1957</b>	Month <b>March</b>	Day <b>25</b>	Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 19 1900</b>
9. AGE (In years last birthday) <b>56</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
13. CITIZEN OF WHAT COUNTRY? <b>USA</b>	14. FATHER'S NAME <b>Clyde O. Shatto</b>	15. MOTHER'S MAIDEN NAME <b>Maude Powers</b>	16. SOCIAL SECURITY NO. <b>214-09-7297</b>
17. INFORMANT <b>Elizabeth Shatto</b>	18. ADDRESS <b>31 Broadway Hagerst</b>	19. INTERVAL BETWEEN ONSET AND DEATH <b>1 hour 15 min</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>			
10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>			
11. BIRTHPLACE (State or foreign country) <b>Sharon Mercer Co Pa.</b>			
12. FATHER'S NAME <b>Clyde O. Shatto</b>			
13. MOTHER'S MAIDEN NAME <b>Maude Powers</b>			
14. SOCIAL SECURITY NO. <b>214-09-7297</b>			
15. INFORMANT <b>Elizabeth Shatto</b>			
16. ADDRESS <b>31 Broadway Hagerst</b>			
17. INFORMANT <b>Elizabeth Shatto</b>			
18. ADDRESS <b>31 Broadway Hagerst</b>			
19. INTERVAL BETWEEN ONSET AND DEATH <b>1 hour 15 min</b>			
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b>			
DUE TO <b>1d 0.0</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <b>Arteriosclerotic Heart Disease</b>			
DUE TO <b>15 years</b>			
C. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
22. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
23. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
24. TIME OF INJURY Month, Day, Year Hour o. m. 19			
25. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
26. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
27. (City or town) (County) (State)			
28. I certify that I attended the deceased from <b>11-16, 1957</b> to <b>3-25, 1957</b> , that I last saw the deceased alive on <b>3-25, 1957</b> , and that death occurred at <b>7:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>154 West Washington St.</b> DATE SIGNED <b>John H. Hornbaker M.D.</b> <b>3:25:57</b>			
29. ACTUAL SIGNATURE			
30. PHYSICIAN'S NAME (Type) <b>John H. Hornbaker, M.D.</b>			
31. PLACE OF DEATH <b>Hagerstown, Maryland</b>			
32. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
33. DATE THEREOF <b>3/27/57</b>			
34. NAME OF CEMETERY OR CREMATORIAL <b>Rest Haven Cemetery</b>			
35. LOCATION (City, town, or county) <b>Hagerstown Wash. Co Md</b>			
36. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagers own M.D.</b>			
37. ADDRESS <b>154 West Washington St.</b>			
38. REC'D BY REGISTRAR <b>Mar 29 1957</b>			
39. REGISTRAR'S SIGNATURE <b>Maude Powers</b>			

RECEIVED  
APR 1 1967

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
03412

03421

302

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Hancock				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS Hancock, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Thomas		First	Middle	Last	4. DATE OF DEATH March 17	Month	Day	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1869		9. AGE (In years lost birthday) 87 yrs.	10. IF UNDER 1 YEAR Months 9	11. IF UNDER 24 HRS Days 8	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Carpenter		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME Jacob Shives		14. MOTHER'S MAIDEN NAME Ellen Sweeney						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Lloyd Shives		Address Hancock, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriolaramepirosclerosis with Uremia 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 12 days		
		(b) Hypertensive cardiovascular disease				indetermin- ate		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Papillary adenocarcinoma bladder				indeterminate		
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hancock	(County)	(State)
21. I certify that I attended the deceased from March 5, 1957, to March 17, 1957, that I last saw the deceased alive on March 17, 1957, and that death occurred at 8:00 P.M., from the causes and on the date stated above ADDRESS (Street, city or town, state) M.D. 100 Professional Arts Bldg. 3-10-57								
ACTUAL SIGNATURE <i>William T. Layman, M.D.</i>		DATE SIGNED						
PHYSICIAN'S NAME (Type) William T. Layman, M.D.		Hagerstown, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/20/1957	22c. NAME OF CEMETERY OR CREMATORIAL St. Thomas Episcopal		22d. LOCATION (City, town, or county) Hancock		(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard J. Glavin, Hancock, Md.</i>		ADDRESS ADDRESS 1003231957						
		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <i>Howard J. Glavin, Hancock, Md.</i>						

LAU Y. S.

MP 28 1957

LAU Y. S.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**03413**  
**CERTIFICATE OF DEATH**

03422

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution, Residence before admission a. STATE		Maryland Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN Tb 14 Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		x. Rural - Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Washington Co. Hospital		d. STREET ADDRESS		Route 6 - Hagerstown	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							

3. NAME OF DECEASED (Type or print)	First CLARA	Middle SUSAN	Last SHUCK	4. DATE OF DEATH	Month March	Day 7	Year 1957
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. UNDER 1 YEAR	11. UNDER 24 HRS	
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12/11/1890	66 yrs.	Months	Days	Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Name	Wash. Co., md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
David H. Martin	Mary Eshleman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO	17. INFORMANT	Address
no	None	Harry H. Shuck - Stat Line, Pa.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Renal Disease, Arteriosclerotic</u>	
442X DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)	
DUE TO	
(c)	
10 yrs.	

MEDICAL CERTIFICATION	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Advanced grade involutional psychosis	

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
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20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from <u>March 7, 1945</u> , to <u>March 7, 1957</u> , that I last saw the deceased alive on <u>March 7, 1957</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	DATE SIGNED
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ACTUAL SIGNATURE <u>W.C. Brewer</u>	M.D. <u>Greencastle, Pa.</u>	5/8/57
PHYSICIAN'S NAME (Type)		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/10/57	22c. NAME OF CEMETERY OR CREMATORIAL Beautiful View	22d. LOCATION (City, town, or county) Wash. Co., md. (State)
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23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Dennis</u>	ADDRESS <u>Greencastle, Pa.</u>	24a. REC'D BY REGISTRAR <u>Mar. 9, 1957</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Powers</u>
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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. G.

MAR 12 1957

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03414

## CERTIFICATE OF DEATH

03423

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md.</b>		c. LENGTH OF STAY IN 1b <b>Life time</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Maryland.</b>		d. STREET ADDRESS <b>131 West Church Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>131 West Church Street</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mattie</b>		First <b>(ne)</b>	Middle <b>Smith</b>	Lost	4. DATE OF DEATH <b>March 1 1867</b>	Month <b>March</b>	Day <b>1</b>	Year <b>1867</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>	8. DATE OF BIRTH <b>May 24 1868</b>	9. AGE (In years last birthday) <b>88 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b>	12. IF UNDER 24 HRS Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private Family</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>			
13. FATHER'S NAME <b>William Braxton</b>		14. MOTHER'S MAIDEN NAME <b>Mattie Lyles</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs Jane Semerville</b>		Address <b>131 W. Church St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic myocardial heart disease</b>						INTERVAL BETWEEN ONSET AND DEATH			
DUE TO  Conditions, if any, which gave rise to Immediate cause (a), stating the under- lying cause last. <b>None</b>		(b)  DUE TO <b>with myocardial failure grade iv</b>							
(c)									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <b>None</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>							
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>None</b> 19 p.m. <b>None</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) <b>None</b>		(County) <b>—</b>	(State) <b>—</b>
21. I certify that I attended the deceased from <b>Feb. 26, 1957</b> to <b>March 1, 1957</b> that I last saw the deceased alive on <b>Feb. 26, 1957</b> , and that death occurred at <b>2:00 P.M.</b> from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <b>115 ... lot 100 Street</b>									DATE SIGNED <b>3-4-57</b>
ACTUAL SIGNATURE <i>S. Robert Wells</i>		M.D.							
PHYSICIAN'S NAME (Type) <b>S. Robert Wells, M.D.</b>		Hagerstown, Maryland							
22a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-4-1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Hagerstown Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John R. Watson, Hagerstown Md</i>		ADDRESS <b>115 ... lot 100 Street</b>							
		24a. REC'D BY REGISTRAR <b>Mar. 7, 1957</b>							
		24b. REGISTRAR'S SIGNATURE <i>Chas H. Powers</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y.

MAR 11 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03428

## CERTIFICATE OF DEATH

03424

Reg. Dist. No.

36

1 PLACE OF DEATH a COUNTY Washington		MARYLAND		2 USUAL RESIDENCE (Where deceased lived) If institution Residence before admission a STATE Maryland		b COUNTY Washington									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural—Williamsport		c LENGTH OF STAY IN 1b 4 Years		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural— Williamsport											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williamsport RFD #2		d STREET ADDRESS Williamsport RFD #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3 NAME OF DECEASED (Type or print)	First Pearl	Middle T.	Last Solomon	4. DATE OF DEATH March 8 1957	Month March	Day 8	Year 1957								
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 26, 1875		9. AGE (In years last birthday) 82 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min									
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b KIND OF BUSINESS OR INDUSTRY Painting		11 BIRTHPLACE (State or foreign country) Franklin West Vt.		12 CITIZEN OF WHAT COUNTRY? USA									
13 FATHER'S NAME G. C. K. Solomon		14 MOTHER'S MAIDEN NAME Jane Harper													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16 SOCIAL SECURITY NO. None		17 INFORMANT Mrs. Ella Solomon		Williamsport, Md. R.F.D. #2									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 411 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Cardiac Failure		INTERVAL BETWEEN ONSES AND DEATH 3 days.		Arteriosclerotic Heart Disease 3 years.									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Williamsport		(County) Washington		(State) Maryland	
21. I certify that I attended the deceased from <u>May 14 1957</u> to <u>8 March 1957</u> , that I last saw the deceased alive on <u>1 March 1957</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.		ACTUAL SIGNATURE Dr. Paul Haak M. D.		ADDRESS (Street, city or town, state) 280 Paxtonae, Williamsport, Md.		DATE SIGNED 8 March 57									
22a BURIAL, CREMATION, REMOVAL (Specify) Burial		22b DATE THEREOF 3/10/57		22c NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery		22d LOCATION (City, town, or county) Williamsport, Maryland		(State)							
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf		ADDRESS Williamsport, Md.		24a REC'D BY REGISTRAR DATE March 8-57		24b REGISTRAR'S SIGNATURE E. Lee McElroy									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03415

CERTIFICATE OF DEATH

Dr Hoffman

03425  
Reg. Dist. No. 302

1. PLACE OF DEATH o COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 14 Hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES WILLIAM STEEN		First Middle Last	4. DATE OF DEATH March 21 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13 1897
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent		10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (State or foreign country) Darby Delaware Co Pa.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William F. Steen	
14. MOTHER'S MAIDEN NAME Ella Eckert		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 214-09-1127		17. INFORMANT Elizabeth G. Steen 1234 Crescent Rd Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 19984 DUE TO Adenocarcinoma Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH 5 mo.	
20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardiovascular Disease.		21. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> p. m. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1953, to March 21 1957, that I last saw the deceased alive on March 20, 1957, and that death occurred at 2 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE Lloyd C. Hoffman M.D. 214 N. Potomac St. Hagerstown 3/23/57 PHYSICIAN'S NAME (Type) Lloyd A. Hoffman 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 3/23/57 22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery 22d. LOCATION (City, town, or county) Hagerstown Wash. Co Md. (State)		24a. ADDRESS Andrew K. Cofinan Hagerstown Md. 24b. REC'D BY REGISTRAR Mar. 25, 1957 24c. REGISTRAR'S SIGNATURE Lloyd C. Hoffman	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Cofinan Hagerstown Md.			

BUREAU V. 2

MAR 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

03426

Dr LeVan

**Reg. Dist. No.**

305

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro R#2</b>		c. LENGTH OF STAY IN 1b <b>1 Yr</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Fahrney-Keedy Memorial Home</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
3. NAME OF DECEASED (Type or print) <b>ORVAS JESSE STOTELMYER</b>		4. STREET ADDRESS <b>42 Broadway</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 15 1869</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Book-keeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>Wolfesville Fred Co USA</b>	
13. FATHER'S NAME <b>Jonathan Stotelmyer</b>		14. MOTHER'S MAIDEN NAME <b>Susan Blickenstaff</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-14-6740</b>	
17. INFORMANT <b>Hubert J. Stotelmyer</b>		Address <b>42 Broadway</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  40-7-1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  DUE TO  (b) DUE TO  (c)		Hagerstown I.d.  Coronary Thrombosis  arteriosclerosis  INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b>  5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 11, 1957</b> to <b>March 7, 1957</b> , that I last saw the deceased alive on <b>March 6, 1957</b> , and that death occurred at <b>Boonsboro</b> M.D., from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Boonsboro, Md.</b>			
ACTUAL SIGNATURE  <b>G. W. Van M.D.</b>		DATE SIGNED <b>3/7/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/9/57</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Dunkard Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Beaver Creek Wash. Co. Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE  <b>Andrew K. Coffman Hagerstown Md.</b>		ADDRESS  <b>MARY</b>	
24a. REC'D BY REGISTRAR  <b>John A. Best</b>		24b. REGISTRAR'S SIGNATURE  <b>John A. Best</b>	

RECEIVED  
BUREAU V. S.

MAR 8 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03416

03427

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>.2 HOURS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASH. Co. HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF -DECEASED (Type or print) <b>WEBSTER WILSON STOTLEMYER</b>		First <b>W</b>	Middle <b>IL</b>
3. NAME OF -DECEASED (Type or print) <b>WEBSTER WILSON STOTLEMYER</b>		Last <b>STOTLEMYER</b>	4. DATE OF DEATH <b>MARCH - 28, 1957</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>FEBRUARY 14 1878</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>	
11. BIRTHPLACE (State or foreign country) <b>WOLFSVILLE FRED. CO. MD. U.S.A</b>		12. CITIZEN OF WHAT COUNTRY? <b>WOLFSVILLE FRED. CO. MD. U.S.A</b>	
13. FATHER'S NAME <b>WILSON STOTLEMYER</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE SHUFF</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONF</b>	
17. INFORMANT <b>AUSTIN STOTLEMYER</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>452X</b> DUE TO <b>Rupture of Aneurysm internal iliac artery (lt.)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hemorrhage and shock</b> DUE TO <b>Coronary thrombosis (old)</b> (c)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>none</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE - <b>S. Robert Wells</b>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		22d. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
22b. DATE THEREOF <b>MARCH 30 1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>BOONS BORO CEMETERY</b>	
22d. LOCATION (City, town, or county) <b>BOONS BORO WASH. Co. MD</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>BEST FUNERAL HOME</b>		24a. REC'D BY REGISTRAR <b>3-30-57</b>	
		24b. REGISTRAR'S SIGNATURE <b>Robert Gowers</b>	

BUREAU V. 2

APR 4 1957

REGISTRATION

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03428

03417

## CERTIFICATE OF DEATH

Reg. Dist. No. 3020

1. PLACE OF DEATH a. COUNTY <b>Washington Co</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b>		b. COUNTY <b>Franklin</b>			
b. CITY, OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>2/22/57</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waynesboro</b>		d. STREET ADDRESS <b>115 Myrtle Ave</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) <b>Washington Co Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Alfred Carl</b>		First	Middle	last	4. DATE OF DEATH <b>Warner</b>	Month <b>3</b>	Day <b>9</b>	Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/3/02</b>	9. AGE (In years last birthday) <b>55 yrs</b>	10. IF UNDER 1 YEAR Months <b>5</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>	13. IF UNDER 24 HRS Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>A. Ritchie Warner</b>		14. MOTHER'S MAIDEN NAME <b>Alvilda Eibee</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>171-28-5547</b>		17. INFORMANT <b>Mrs. A. Carl Warner, 115 Myrtle Ave. Waynesboro,</b>		Address <b>Penna.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>447X</b>		DUE TO (b)		INTERVAL BETWEEN ONSET AND DEATH <b>Uremia - Pyelonephritis - Chronic yrs</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first <b>hypertensive vascular Disease</b>		DUE TO (c)		Hypertensive Vascular Disease					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>2-26-1957</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> not work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>832 Potomac ave</b>		20f. (City or town) (County) <b>Waynesboro</b> (State) <b>Pa.</b>			
21. I certify that I attended the deceased from <b>2-26-1957</b> to <b>3-9-1957</b> that I last saw the deceased alive on <b>3-9-1957</b> , and that death occurred at <b>5:31 P.M.</b> from the causes and on the date stated above				ADDRESS (Street, city or town, state) <b>832 Potomac ave</b>		DATE SIGNED <b>3-9-57</b>			
ACTUAL SIGNATURE <b>J. G. Warden</b>		M.D.							
PHYSICIAN'S NAME (Type) <b>J. G. WARDEN</b>		MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/12/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Green Hill</b>		22d. LOCATION (City, town, or county) <b>Waynesboro</b> (State) <b>Pa.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Father J. G. Warden, Pa.</b>		ADDRESS <b>115 Myrtle Ave, Waynesboro, Pa.</b>		24a. REC'D BY REGISTRAR <b>Mar. 12, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Franklin</b>			

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03429

03418

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Tenn. b. COUNTY Shelby		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 4 Weeks			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Memphis 79X		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Nursing Home			d. STREET ADDRESS 1826 Lamar Pl.		
3. NAME OF DECEASED (Type or print) Isabelle Lucille White			4. DATE OF DEATH Month Day Year March 13 19 57		
5. SEX Female White			6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> May 31, 1914		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife			10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Quincy Pa.		
13. FATHER'S NAME Robert N. Haldeman			14. MOTHER'S MAIDEN NAME Bessie Sanders		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 17. INFORMANT Richard Haldeman Address North Wales Pa.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 305X DUE TO <i>Pylitis chronic</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>E. Coli</i> (c) DUE TO <i>Decubitus ulcers.</i>			INTERVAL BETWEEN ONSET AND DEATH 3 months		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>Sept 21 1956</i> to <i>April 13 1957</i> , that I last saw the deceased alive on <i>March 13 1957</i> , and that death occurred at <i>8:30 P.M.</i> from the causes and on the date stated above.			ADDRESS (Street, city or town, state) M.D. <i>159 W. Washington St. Hagerstown, Maryland</i> DATE SIGNED <i>Philip J. Hirshman</i> <i>3/18/57</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 3/17/57		
22c. NAME OF CEMETERY OR CREMATORIAL Quincy			22d. LOCATION (City, town, or county) Quincy, Franklin Pa.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter H. Grove</i>			ADDRESS <i>Waynesboro Pa.</i>		
24a. REC'D BY REGISTRAR <i>Mar. 16, 1957</i>			24b. REGISTRAR'S SIGNATURE <i>Chas H. Beavers</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 19 1957

REGISTRY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03430

## CERTIFICATE OF DEATH

113430  
302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>PA.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MAUGANSVILLE</b>		c. LENGTH OF STAY IN 1b <b>17 MOS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MENNONITE CHURCH HOME</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - HAMILTON TWP.</b>	
3. NAME OF DECEASED (Type or print) <b>MARY</b>		First <b>Mary</b>	Middle <b>Alice</b>
4. DATE OF DEATH <b>MARCH 17, 1957</b>		Last <b>WENGERT</b>	Month Day Year
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 26, 1869</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (State or foreign country) <b>EDGEMONT, MD</b>
13. FATHER'S NAME <b>JOHN</b>		14. MOTHER'S MAIDEN NAME <b>MARY STOUFFER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>	17. INFORMANT <b>ABRAM P. LEIGHT, Chambersburg, Pa</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hyper-acute myocardial Infarction</b>		Address <b>1034 L.W.W</b>	
DUE TO <b>Hyper-tensive cardiac vascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs</b>	
DUE TO <b>Arteriosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Possible orthostatic pneumonia</b>		19. WAS AUTOPSY PERFORMED? <b>NO</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 15, 1956</b> , to <b>Mar 17, 1957</b> , that I last saw the deceased alive on <b>June 15, 1956</b> , and that death occurred at <b>4:30 PM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Edward W. Dittman M.D.</b>		ADDRESS (Street, city or town, state) <b>212 W. Washington St</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAR. 19, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>NORLAND CEM.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>SELLERS FUNERAL HOME CHAMBERSBURG, PA.</b>		24a. ADDRESS <b>—</b>	24b. REC'D BY REGISTRAR <b>Mar. 22, 1957</b>
		24c. (State) <b>PA.</b>	24d. REGISTRAR'S SIGNATURE <b>W. S. Powers</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

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MAR 9 1957

REGELIVE

## MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

03431

03419

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 18 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 516 Washington Square		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JOSEPHUS	Middle RUBY	Last WOLFKILL	4. DATE OF DEATH	Month March	Day 3	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Jan. 9, 1884	9. AGE (In years lost birthday) 73	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Aircra ft		11. BIRTHPLACE (State or foreign country) Chambersburg, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry Edmond Wolfkill		14. MOTHER'S MAIDEN NAME Emma Jones					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-0198		17. INFORMANT Mrs. Chas. W. Miller		Address 1940 Greenfield Road Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line 18 (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 5 days			
		General Arterio Sclerosis		10 yrs.			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb. 1, 1957</u> to <u>March 2, 1957</u> that I last saw the deceased alive on <u>March 1, 1957</u> , and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <u>Hagerstown, Md.</u>			
ACTUAL SIGNATURE <u>Jack Henson Beachley</u>		M.D.		DATE SIGNED <u>03/14/57</u>			
PHYSICIAN'S NAME (Type)		Jack Henson Beachley M.D. 221 W. Washington St. Hagerstown, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/5/57		22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		ADDRESS		24a. REC'D BY REGISTRAR Mar. 5, 1957		24b. REGISTRAR'S SIGNATURE G. H. H. Flowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BEREA V. S.

MAR 7 1957

LIBRARY

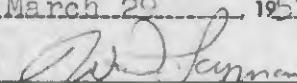
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03420

## CERTIFICATE OF DEATH

03432  
302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 22 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 28 East Washington Street		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
3. NAME OF DECEASED (Type or print) WILLIAM		First HENRY	Middle WOODYATT
4. DATE OF DEATH March		Month March	Day 29
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH October 22, 1871		9. AGE (In years last birthday) 85 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Foreman		10b. KIND OF BUSINESS OR INDUSTRY Furniture Manufacture	11. BIRTHPLACE (State or foreign country) Staffordshire, Eng.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Arthur Woodyatt	
14. MOTHER'S MAIDEN NAME Charlotte Priest		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 214-09-1994		17. INFORMANT Mrs. Maly L. Woodyatt Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3½ yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus, mild		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 26, 1957</u> , to <u>March 29, 1957</u> , that I last saw the deceased alive on <u>March 20, 1957</u> , and that death occurred at <u>7:35 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 100 Professional Arts Building DATE SIGNED 3-29-57			
ACTUAL SIGNATURE 		PHYSICIAN'S NAME (Type) William T. Layman, M.D. Hagerstown Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/1/1957	22c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery
22d. LOCATION (City, town, or county) Hagerstown, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home R. Franklin Rouzer		24a. REC'D BY REGISTRAR 3/1/1957	24b. REGISTRAR'S SIGNATURE 

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
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## CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
03421 CERTIFICATE OF DEATH

03433

Reg. Dist. No. *302*

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		d. STREET ADDRESS <b>734 WASHINGTON AVE.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>DAVID</b>		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>3/2/57</b>		9. AGE (In years lost birthday) yrs. <b>03</b>	10. IF UNDER 1 YEAR Months <b>03</b>	11. IF UNDER 24 HRS. Days <b>19</b>	12. IF UNDER 24 HRS. Hours <b>57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>CONRAD H. YOUNGBLOOD</b>				14. MOTHER'S MAIDEN NAME <b>JANET JOHNSON</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MR. CONRAD H. YOUNGBLOOD</b>		Address <b>HAGERSTOWN MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Mucoviscidosis</i> INTERVAL BETWEEN DUE TO <i>756.6</i> ONSET AND DEATH <i>2 days</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Congenital cystic disease of lung</i> DUE TO <i>4 day</i> (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>2/17/57</b> , 1957, to <b>6/17/57</b> , 1957, that I last saw the deceased alive on <b>6/17/57</b> , 1957, and that death occurred at <b>4:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hagerstown, Md.</b> DATE SIGNED <b>7/1/57</b>									
ACTUAL SIGNATURE <i>Edward Boardman</i>		M.D.							
PHYSICIAN'S NAME (Type) <b>Edward Boardman</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/8/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>REST HAVEN CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Horment, Hagerstown Md.</b>				24a. ADDRESS <b>208192 K-16</b>		24b. REC'D BY REGISTRAR <b>Mar. 9, 1957</b>		24c. REGISTRAR'S SIGNATURE <b>Charles H. Powers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2024 MARCH 17 (10:00 AM KST) | 2024 MARCH 17 (10:00 AM KST)

BUREAU A. 2

MAR 12 1957

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